April 2008

CODING

MENTAL HEALTH CODING HANDBOOK

Version 1.0

Guidance on Air Force Coding Standards

PREPARED BY:

Air Force Medical Operations Agency
AFMOA/SGH
2509 Kennedy Circle
Brooks City-Base, TX 78235-5116

&

Community Behavioral Health Division
Air Force Medical Operations Agency
AFMOA/SG3OO
5201 Leesburg Pike, Suite 1501B
Falls Church, VA 22041

POINTS OF CONTACT:

Lt Col Tracy Neal-Walden, PhD
Chief, Population Health Enhancement
DSN 240-4257
tracy.neal-walden@brooks.af.mil

Lt Col Steven Pflanz, MD
Senior Psychiatry Policy Analyst
DSN 761-6212
steven.pflanz@pentagon.af.mil

Maj Nicole Frazer, PhD
Chief, Air Force Substance Abuse Program Development
DSN 761-6506
nicole.frazer@pentagon.af.mil

Ms. Cindy Pierson, GS-13, RHIA
Consultant for Ambulatory Health Information Management and Coding
DSN 240-4080
cindy.pierson@brooks.af.mil

Ms. Sandra Kunze, CPC, CPC-H
Coding Compliance Consultant
DSN 240-4123
sandra.kunze@brooks.af.mil

ACKNOWLEDGEMENTS

This document was developed by AFMOA/SGH, Air Force Medical Operations Agency (AFMOA), Office of the USAF Surgeon General in conjunction with the Community Behavioral Health Division, Air Force Medical Operations Agency (AFMOA), Office of the USAF Surgeon General and the Air Education and Training Command (AETC).

Special thanks to Lesvia Millican, CPC, for the contributions provided in this guidance and to the coders, auditors and mental health providers across the Air Force.

COPYRIGHT

U.S. Government Rights

TABLE OF CONTENTS

OVERVIEW

This section provides an overview of the information covered in this handbook. This handbook supersedes the Military Healthcare System (MHS) Professional Services and Specialty Coding Guidelines.

Purpose

The purpose of this handbook is to provide updated guidance on Air Force (AF) coding standards to assist clinicians in the field accurately code clinical mental health services. The coding standards described in this handbook represent the official position of the Air Force Medical Service (AFMS) regarding mental health coding practices. Although a few encounters could be coded in more than one way, to ensure standard coding practices, clinicians and coders will adhere to these mental health coding standards. This handbook is accompanied by a policy letter from the Assistant Surgeon General for Health Care Operations, Major General Thomas Loftus, mandating the use of these practices across the AFMS for clinicians, coders, and coding auditors.

Departments Involved

AFMOA/SGH in collaboration with AFMOA/SG3OO and AETC and various clinical representatives from the fields of Psychiatry, Psychology, and Social Work across the AFMS and select AF coding representatives formed a second Mental Health Coding Integrated Product Team (IPT) in March 2007 and developed these standards.

Specialties Covered

This handbook is divided into the following sections: General Mental Health-Ambulatory, Clinical Health Psychology (CHP), Neuropsychology, Behavioral Health Optimization Program (BHOP)-Behavioral Health Consultation (BHC), Alcohol and Drug Abuse Prevention and Treatment (ADAPT), and the Family Advocacy Program (FAP). The specific coding guidance within each section refers to the codes that licensed (or potential to be licensed in cases where the provider is not yet licensed) credentialed providers should use. *For services provided by provider extenders (e.g. Certified Alcohol and Drug Abuse Counselors [CADACs]), refer to page 11.*

Future Revisions

This handbook will be revised to reflect changes in the AMA coding guidance. AFMS audits will be used to monitor coding practices using the Biometric Data Quality and Assurance Service (BDQAS) and the Surgeon General's Executive Global Look (SG/EGL) for adherence to these coding standards.

DEPARTMENT OF THE AIR FORCE
HEADQUARTERS UNITED STATES AIR FORCE
WASHINGTON DC

29 April 2008

MEMORANDUM FOR ALMAJCOM/SG

FROM: HQ USAF/SG3
110 Luke Avenue, Room 400
Bolling AFB DC 20032-7050

SUBJECT: Air Force Mental Health Coding Handbook Revision

In October 2005, the Air Force published its first Mental Health Coding Handbook. This handbook represented the combined efforts of over 40 psychiatrists, psychologists, social workers and coders, including the lead coders in the Navy, Army, members of the Unified Biostatistical Utility and experts at TMA. Implementation of this guidance has led to greater standardization and accuracy in our medical coding practices.

With changes in coding requirements from the American Medical Association, our evolving clinical mission, and feedback from clinicians in the field, the Mental Health Coding Handbook has been revised and updated by Air Force subject matter experts. This revision also includes guidance for proper use of Medical Expense Performance Reporting Systems (MEPRS) codes within the mental health product line.

Please disseminate this handbook to installations for immediate use. My point of contact for this matter is Lt Col Tracy Neal-Walden, Air Force Behavioral Health Optimization Program Manager, AFMOA/SGHC, (210) 536-4257, DSN 240-4257, or Tracy.Neal-Walden@Brooks.af.mil.

THOMAS J. LOFTUS
Major General, USAF, MC, CFS
Assistant Surgeon General, Health Care Operations
Office of the Surgeon General

Attachment:
Mental Health Coding Handbook, Version 1.0

SG3 DOC: 08-067

INTRODUCTION

This section provides an introduction to the basic concepts of coding including a discussion of Evaluation and Management (E&M) service codes, CPT codes, International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) codes, criteria for use of E&M codes, documentation issues, and specific highlighted coding issues. For a detailed understanding, review the CPT and the ICD-9-CM texts.

Coding entails assigning appropriate diagnoses and codes (E&M and CPT) that describe the services performed during the clinical encounter. E&M and CPT codes are used to "pay" the Military Treatment Facility (MTF) for the services performed. Inaccurate coding can cost the MTF money. In addition, fraudulent coding (knowingly engaging in inaccurate coding) is subject to disciplinary action.

From the CPT 2008 Professional Edition: "It is important to recognize that the listing of a service or procedure and its code number in a specific section of this book does not restrict its use to a specific specialty group. Any procedure or service in any service in any section of this book may be used to designate the services rendered by any qualified physician or by a qualified health care professional." This revision of the Mental Health Coding Handbook incorporates this guidance. This resulted in significant changes to the use of E&M codes by mental health providers, with greater use of the E&M codes throughout the handbook.

E&M Codes

E&M codes are used to describe services provided by physicians to patients in order to evaluate and manage their care. As a general rule, all mental health providers, including psychiatrists, psychologists, and social workers, will use the E&M code **99499** along with the appropriate procedure code. The E&M code **99499** is a "dummy code," it has no value or meaning except to hold a place in the Composite Health Care System (CHCS), which requires an E&M code.

In cases where the encounter is more appropriately captured with an E&M code (e.g. **99411-99412**, **99391-99397**), the documentation and use of the psychiatric worksheet (*see Appendix A*) must support the use of the E&M code. As mentioned, this is a change from the previous Mental Health Coding Handbook, and the following section is intended to provide information to assist mental health providers in the correct use of E&M codes.

See individual sections for examples.

Consultations

A consultation is a type of service offered by a provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another provider or another appropriate source (e.g. physician assistant, nurse practitioner, physical therapist, psychologist, social worker or lawyer).

A provider consultant may initiate diagnostic and/or therapeutic services at the same or subsequent visit.

The written or verbal request for a consultation may be made by a provider or other appropriate source and documented in the patient's medical record. The consultant's opinion and any services that were ordered or performed must also be documented in the patient's medical record and communicated by written report to the requesting provider or other appropriate source.

A consultation initiated by a patient and/or family, not requested by a physician or other appropriate source, is not reported using the consultation codes but may be reported using office visit E&M codes or an appropriate psychiatric CPT code.

Any specifically identifiable procedure (i.e. identified with a specific CPT code) performed on or subsequent to the date of the initial consultation should be reported separately.

Remember, the three R's for consultation are:

1. Request for services received
2. Render services
3. Response given in written format

Consultation codes may be appropriate for inpatient ward consults, Emergency Room (ER), and BHC. *Refer to the General Mental Health and BHOP sections for further information*.

See Appendix B for coding of consultations.

Preventive Medicine: Counseling and/or Risk Factor Reduction Intervention

These codes are used to report services provided to individuals at a separate encounter for the purpose of promoting health and preventing illness or injury.

Preventive medicine counseling and risk factor reduction interventions provided as a separate encounter will vary with age and should address such issues as:

- family problems
- diet and exercise
- substance abuse
- sexual practices
- injury prevention
- dental health
- diagnostic and laboratory test results available at the time of the encounter

These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness.

Preventive Medicine, Individual Counseling

99401 Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes
99402 approximately 30 minutes
99403 approximately 45 minutes
99404 approximately 60 minutes

Preventive Medicine, Group Counseling

99411 Preventive medicine counseling and/or risk factor reduction intervention(s) provided in a group setting (separate procedure); approximately 30 minutes
99412 approximately 60 minutes

Other Preventive Medicine Services

99420 Administrative and interpretation of health risk assessment instrument (e.g. health hazard appraisal)
99429 Unlisted preventive medicine services

Example A:

A 45-year-old active duty member fails the fitness test with a score of 68. He attends the Healthy Living Program group led by the privileged provider (e.g., clinical psychologist, social worker, psychiatrist, etc) and states he has difficulty finding time to exercise and thus performed poorly on the mile and a half run. He sets a goal to increase his exercise behavior and during the group learns how to make a reasonable, realistic goal. He leaves the group with a clearly stated goal and a clear understanding of how to meet that goal and various relapse-prevention strategies. This 90-minute encounter is coded E&M **99412** and ICD-9-CM **V65.41**, exercise counseling.

Example B:

A 60 minute stress management class with standard curriculum is led by a privileged provider at the Health and Wellness Center (HAWC). This class is coded E&M **99412** and ICD-9-CM **V65.49__A**, stress education.

CPT Codes (Procedure Codes)

Procedure codes describe procedures or services performed during the patient encounter (e.g., biopsy, immunization, or counseling). For mental health care, the CPT codes are well-defined and capture a great deal of the spectrum of care, including the care provided by psychiatrists, psychologists, and social workers. Use these codes with E&M code **99499**.

Choosing the appropriate CPT code depends in part on the patient's diagnosis. If mental health symptoms or diagnoses are being documented, then use of *Psychiatric* codes such as **90801-90815** and **90853** is appropriate. If physical symptoms or non-psychiatric diseases (diabetes, obesity, etc) (AXIS III conditions diagnosed by a physical medicine provider) are being documented, then use of the *Health and Behavior* codes such as **96150-96155** is appropriate.

ICD-9-CM Diagnostic Codes

The ICD-9-CM codes are used by providers to characterize the complete clinical picture for a patient. It is imperative that clinicians be knowledgeable of the ICD-9-CM codes as these are the codes that must be used for data entry.

The military also has developed a set of unique encounter codes. These codes have recently been updated and are as follows:

Description	Code
Cancer Education	**V65.49_0**
Medication Education	**V65.49_1**
Hormone Replacement Education	**V65.49_2**
Calcium Replacement Education	**V65.49_3**
Tobacco Cessation Counseling	**V65.49_4**
Travel Medicine Education	**V65.49_5**
Occupational Exposure Education	**V65.49_6**
Occupational Stress Education	**V65.49_7** (*formerly* V62.1_ _0)
Mental Health Education	**V65.49_8** (*formerly* V62.81_0)
Other Specified Counseling	**V65.49_9**
Stress Education	**V65.49A** (*formerly* V62.81_1)
Suicide Education	**V65.49B** (*formerly* V62.81_2)
Alcohol Education	**V65.42_0**
Substance Abuse Counseling	**V65.42_1**

Description	Code
Armed Forced Medical Examination	V70.5_0
Aviation Examination	V70.5_1
Periodic Prevention Assessment/ Examination	V70.5_2
Occupational Examination	V70.5_3
Pre-Deployment Related Encounter	V70.5_4
Intra-Deployment Encounter	V70.5_5
Post-Deployment Related Encounter	V70.5_6
Duty Status Determination Encounter	V70.5_7
Special Program Accession Encounter	V70.5_8
Separation/Termination/Retirement Examination	V70.5_9

See BDQAS for the entire list of MHS specific extender codes-https://bdqas.brooks.af.mil/

It is important that providers use the primary ICD-9-CM as the reason the patient was seen. In addition to the primary ICD-9-CM code, providers are encouraged to use additional codes. Therefore, DO NOT code probable, rule out, suspected or questionable diagnoses as if they are established. Rule out diagnoses can be entered in the Armed Forces Health Longitudinal Technology Application (AHLTA) for documentation purposes into the comments free-text box associated with the primary diagnosis.

No Diagnosis Code V71.09

Mental health providers are trained to conduct psychiatric evaluations and in cases where no psychiatric condition is found, to indicate V71.09 on DSM-IV AXIS I and AXIS II. However, for data entry (i.e. coding) purposes, this is not the most accurate representation of the clinical encounter as the goal in assigning a code is to indicate the "reason the person was seen by you." The person was not seen because they had no diagnosis. They were seen because they had symptoms or complaints of difficulties that were then evaluated. Therefore, in cases where no psychiatric diagnosis is given (i.e. a V71.09 code to AXIS I and AXIS II will be assigned), the mental health provider must do two things: Indicate **V71.09** as the primary diagnosis AND list a secondary diagnosis (i.e. the "reason they were seen by you").

The secondary diagnosis code could reflect the presenting symptom or complaint (e.g. **780.79**, feeling tired or poorly, **780.93**, memory lapses, **783.0**, decreased appetite, **784.5**,

slurred speech, etc.) or code an AXIS III condition diagnosed by a physical medicine provider (e.g. a patient with diabetes was referred to rule out depression). The secondary code might also be an ICD-9-CM screening code such as **V79.0**, screening for depression, **V79.1**, screening for alcoholism or **V79.2**, screening for mental retardation.

For encounters for the purpose of security clearance, special duty evaluations, etc. in which no diagnosis is found, (i.e. **V71.09**), use code **V68.0X** issue of medical certificate primarily. This indicates there was no psychiatric diagnosis. In AHLTA for Axis II, document (in free text) that there was no diagnosis found on examination of the patient.

Secondary Diagnosis Codes

In cases where the reason for the visit would be most appropriately captured by a secondary diagnosis code (as indicated in the ICD-9-CM manual as SDx) (e.g. **V62.82**, bereavement), **V65.49_9,** other specified counseling, must be the primary ICD-9-CM code.

Some secondary codes frequently used by mental health providers include the following:

V11 Personal History of Mental Disorder	
Schizophrenia	**V11.0**
Affective disorder	**V11.1**
Neurosis	**V11.2**
Alcoholism	**V11.3**
Other specific mental disorder	**V11.8**
Unspecified mental disorder	**V11.9**
V11 Psychological Trauma	
History of physical abuse or rape	**V15.41**
History of psychological abuse	**V15.42**
History of other psychological trauma	**V15.49**
V15.8 Other specified personal history presenting hazards to health	
Noncompliance with treatment	**V15.81**
History of tobacco use	**V15.82**
V40-V49 Persons with Conditions influencing their health status	
Behavioral and mental problems-problems with learning	**V40.0**
Behavioral and mental problems-problems with communication (including speech)	**V40.1**
Problems with special senses and other special functions-problems with sight	**V41.0**
Problems with special senses and other special functions-	**V41.2**

problems with hearing	
Problems with special senses and other special functions-problems with voice production	V41.4
Problems with special senses and other special functions-problems with smell and taste	V41.5
Problems with special senses and other special functions-problems with swallowing and mastication	V41.6
Problems with special senses and other special functions-problems with sexual function	V41.7
V60 Housing, household, and economic circumstances	
Lack of Housing	V60.0
Inadequate Housing	V60.1
Inadequate material resources	V60.2
Person living alone	V60.3
No other person able to give care	V60.4
V62 Other Psychosocial Circumstance	
Unemployment	V62.0
Adverse effects of work environment	V62.1
Occupational problem	V62.2
Educational circumstances-Academic problem	V62.3
Social maladjustment-Acculturation problem	V62.4
Legal system interaction	V62.5
Refusal of treatment for reasons of religion or conscience	V62.6
V62.8 Other psychological or physical stress, not elsewhere classified	
Bereavement	V62.82
Counseling for perpetrator of physical/sexual abuse	V62.83
Phase of life problem; religious or spiritual problem; Borderline intellectual functioning	V62.89

For deployment related exams, always list the appropriate deployment code as the **PRIMARY** ICD-9-CM coded **V70.5_4**, pre-deployment related encounter, **V70.5_5,** intra-deployment encounter, or **V70.5_6**, post-deployment related encounter, and assign codes for any other conditions identified.

Provider Extenders

Mental health technicians are well-trained provider extenders and can be used to facilitate appropriate assessment and treatment in a variety of settings (e.g. facilitating group

treatment, prevention education, CADACs in ADAPT, or neuropsychological technicians). With the appropriate training, certification, and supervision, mental health technicians serve in a variety of important clinical roles. Supervision is defined as direct, "eyes-on," or consultative depending on the task and the training of the technician. For initial assessment, development of or changing a treatment plan, and crisis intervention, the privileged providers are always responsible for direct "eyes on" supervision. Reference AFI 44-119, *Clinical Performance Improvement,* for further information.

All provider extenders, including both 4C mental health technicians and 4C CADACs, will be entered into AHLTA as paraprofessionals and will code the clinical encounters they perform. In the past, there has been confusion regarding CADACs and mental health technicians who are listed as assigned to a PEC 88723 slot on the Unit Manning Document (UMD). These individuals will enter their work in AHLTA in the same manner as the other CADACs and mental health technicians who are not assigned to PEC 88723 slots on the UMD. For all CADACs and mental health technicians, the clinical encounter will be reflected as workload non-count.

The majority of healthcare encounters conducted solely by a mental health technician will be coded using E&M **99211**. In certain clinical encounters in which the mental health technician or CADAC provides education or training for patient self-management, an E&M code of **99499** and the procedure codes **98960-98962,** education and training for patient self-management, may be used. For example, a patient with an anxiety disorder being taught relaxation techniques by a qualified mental health technician might be coded with an E&M **98960-98962**.

The licensed (or potential to be licensed in cases where providers have not yet become licensed), credentialed providers must co-sign for services performed solely by a provider extender. In AHLTA this is accomplished in the co-signature module. Historically, providers have been coding the actual service given by the provider extender and listing the extender as a secondary provider. This is an incorrect practice.

Example A:

A patient walks-in to the mental health clinic. A mental health technician meets with the patient and gathers what is considered standard intake information. The provider reviews the intake information with the technician and meets with the patient to complete the evaluation. This encounter is code E&M **99499** and CPT **90801**. In this case, the technician could be listed as a secondary provider (i.e. paraprofessional, not assisting provider).

Example B:

A patient walks into the mental health clinic. The patient is a current patient of the mental health clinic and is being seen in mental health for work stress. Her AXIS I diagnosis is V65.49_9, other specified counseling, and secondary code V62.2, occupational problem. She presents in distress over an argument she had with her supervisor that day. The mental health technician meets with the patient as the patient's current provider is in session with another patient. The mental health technician assesses the patient's mental status and suicide risk status. The patient's current provider then sees the patient and completes a single system psychiatric exam worksheet, with expanded problem focused history, an expanded problem focused exam and medical decision making of low complexity. This encounter is coded E&M **99213** and the mental health technician is listed as secondary provider (paraprofessional) on the encounter. Time could be considered a factor for counseling and coordination of care.

Example C:

A CADAC teaches session 4 of a 10-week manualized group therapy treatment for alcohol abuse under a credentialed, licensed (or potential to be licensed in cases where providers have not yet become licensed) provider. The CADAC has been observed teaching this group in the past and has been provided feedback and supervision from the credentialed, licensed provider. During this group, the provider is not present and does not directly provide any face-to-face service to the patients. The provider does provide weekly supervision to the CADAC providing this clinical encounter. This session is coded E&M **99211** and the provider co-signs the notes in AHLTA.

Modifiers

In certain circumstances a clinical service provided may exceed the definition of one code and fall short of the definition of the next appropriate code. Three modifiers are recommended for use, they include:

22- Increased Procedural Services: When the service(s) provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure number.

52- Reduced Services: Under certain circumstance a service or procedure is partially reduced or eliminated at the provider's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52.

59- Distinct Procedural Service: Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 59.

Example A:

A patient is seen for 65 minutes of individual face-to-face psychotherapy. The definition of CPT 90806, 45-50 minutes face-to-face individual psychotherapy, is exceeded but the criterion for CPT 90808 (which is 75 to 80 minutes face-to-face individual psychotherapy) is not met. This encounter is appropriately captured with E&M **99499** and CPT **90806-22**.

Example B:

A patient with a complex history and difficulties answering questions succinctly is seen for three hours for a diagnostic interview. This is longer than typical for a diagnostic interview and is properly coded E&M **99499**, CPT **90801-22**. It is incorrect to code as E&M 99499 and CPT 90801 (3 units of service) because time is not a factor for this procedure.

Historically, the E&M code 99358 was used to capture prolonged services. This code is no longer recommended for use since it must be used with another E&M code. Instead, the CPT modifier 22 is recommended for use as appropriate.

Multiple Visits in a Day

According to DoD 6010.13M AP2.1.134.3.3.3; when a patient is seen by more than one healthcare provider in the same clinic (same B*** MEPRS) for the same episode of care, only one visit is counted per patient. However, it is not uncommon for a patient to be seen in the mental health clinic for multiple procedures (e.g. encounters) by the same provider or different providers for the same diagnosis. These encounters can be coded and captured in AHLTA in accordance with the following:

Example A:

The same provider sees the same patient for the same diagnosis, but conducts different procedures within the same day. A provider sees a patient at 0830 for a 90-minute stress management group and sees the same patient at 1100 for a 30-minute individual psychotherapy session. Both encounters are combined and coded E&M **90853-59** and **90804**. Documentation for both appointments is made on the initial encounter for that date. The second appointment is canceled/admin out.

Example B:

Different providers within the same B*** MEPRS (e.g. both work in BFDA) see the same patient for the same procedure within the same day. A psychologist sees a patient at 0830 for individual psychotherapy lasting 50 minutes and the patient returns at 1130 in crisis and is seen for 25 minutes by a social worker (her primary provider is unavailable). This is coded as two different encounters. The first encounter with the psychologist is coded E&M **99499** and CPT **90806**. During the crisis appointment, the patient states that she is thinking of harming herself and does not feel safe with herself. The provider completes a single system psychiatric exam worksheet, with expanded problem focused history and exam, and medical decision making of low complexity. She is seen for approximately 25 minutes by the clinical social worker for a focused risk assessment. The patient consents to inpatient psychiatric hospitalization and awaits transportation to a civilian facility. The encounter with the clinical social worker is coded E&M **99213**, and ICD-9-CM **V70.2** must be the primary diagnosis. The patient's secondary diagnosis will be the diagnosis per history/notes. Time could be considered a factor for counseling and coordination of care.

Example C:

The same provider sees the same patient for two appointments within the same day. A provider sees a patient at 0830 for a 30-minute individual psychotherapy session. The patient returns at 1130 in crisis. The initial encounter is coded E&M **99499** and CPT **90804**. The second encounter for that day should be coded with the crisis diagnosis and the appropriate E&M and/or CPT code for services provided.

Example D:

Different providers within the same B*** MEPRS (e.g. both work in BFDA) see the same patient for different procedures within the same day. A psychologist sees a patient at 0830 for a 50-minute individual psychotherapy session and the patient returns at 1130 for a medication management appointment with a psychiatrist. Both encounters are combined. The encounters with both the psychologist and psychiatrist would be combined and coded E&M **99499** and CPT **90806** for the psychologist and **90862** for

the psychiatrist. Link each code to the provider of that service. Documentation for both appointments is made on the initial encounter for that date. The second appointment is canceled/admin out.

Count versus Non-count

Clinical encounters for a privileged provider always default to count visits. Provider-extender visits are non-count visits.

There have been long-standing concerns regarding the lack of understanding on how to account for workload and expenses in the AFMS. Privileged and non-privileged providers are vital to the success of the AFMS, and data collection of work being performed has a direct impact on the budgetary process. As a note, the "count" and "non-count" terminology is used by the information systems (CHCS, Expense Assignment System [EAS], AHLTA), and is not meant as a reflection of the value of work being performed. MTFs need to use non-privileged providers (non-count feature in systems) to capture and code patient encounters that do not meet the visit definition criteria. Whereas, privileged providers are seen as "revenue generators," the support staff members are the "cost avoiders," a role just as critical for success.

Relative Value Units (RVUs) are not determined by the "count" or "non-count" status of an encounter.

Units of Service

Units of service must be entered where appropriate. Examples of CPT codes requiring units of service are mentioned throughout this handbook. These codes are as follows: CPT **96101**, **96102**, **96118**, **96119**, **96116**, **96152**, **96153**. While AHLTA accepts additional units of service for computer administered psychological testing i.e. 96103 and 96120, these codes are not based on time and units would not be applicable.

Example:

The health and behavior intervention code 96153 is based on 15 minutes of service. If a 90-minute cardiac rehabilitation program is conducted, then it would be coded E&M **99499** and CPT **96153** with 6 units of service.

Psychological Testing

According to the CPT, psychological testing codes are used to report the services provided during testing of cognitive function of the central nervous system. The testing of cognitive processes, visual motor response, and abstractive abilities is accomplished by the combination of several types of testing procedures. It is expected that the administration of these tests will generate material that will be formulated into a report. Psychological testing includes administration, interpretation, and report, per hour. Therefore, entering the units of service performed is critical. Examples are given in later sections under psychological testing.

In January 2006 & 2008, changes were made to the CPT codes for psychological testing. The revised psychological and neuropsychological testing codes now reflect who does the testing: a psychologist, a technician or a computer. The neurobehavioral status exam, which is typically not conducted by a technician or a computer, will be replaced by a single new code.

The revised codes provide more appropriate recognition for psychologists who administer psychological and neuropsychological tests.

In 2006, the code for psychological testing, interpretation and reporting, currently known as 96100, was replaced by:

96101	Psychological testing, per hour of the health care provider's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.
96102	Psychological testing with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face
96103	Psychological testing administered by a computer, with qualified health care professional interpretation and report.

Note: 96101 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests. Do not report 96101 for the interpretation and report of 96102, 96103.

Neuropsychological testing became:

96118 Neuropsychological testing, per hour of the health care provider's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report.

96119 Neuropsychological testing, with qualified health care professional interpretation and report, administered by a technician, per hour of technician time, face-to-face.

96120 Neuropsychological testing by a computer, with qualified health care professional interpretation and report.

Note: 96118 is also used in those circumstances when additional time is necessary to integrate other sources of clinical data, including previously completed and reported technician- and computer-administered tests. Do not report 96118 for the interpretation and report of 96119 or 96120.

It is important to also note that 96103 and 96120 are not time based. For example: Patient A may be asked to complete 3 different psychological computer based tests (and spends 3-5 hours completing) and the next day Patient B comes in for a different type of evaluation and is asked to take a computer based psychological test that takes 25-30 minutes. Both tests will be coded E&M **99499** and CPT **96103**. Us the appropriate qualified healthcare professional **96101,** or technician code, **96102** if greater levels of interaction are required, even though the test was computer administered.

The neurobehavioral status exam is now coded as **96116**. There is only a single code reflecting the psychologist's work in conducting the exam typically not conducted by a technician or a computer. For example, a provider completes a diagnostic interview and Mini Mental Status Examination (MMSE) with an elderly patient related to complaints of memory problems. Code these encounters as E&M **99499** and CPT **90801** and **96116**.

Example:

A patient comes in on Monday as scheduled for a clinical interview and psychological testing. The patient completes the clinical interview. Because of fatigue issues and unforeseen childcare problems, testing is broken into several appointments over the following days. The patient returns on Tuesday to complete 3 hours of computer based psychological testing. Before testing, the provider spends 20 minutes face-to-face with the patient assessing whether there are current symptoms interfering with testing, answering patient questions about testing and clarifying and expanding history and diagnostic information from the interview on the previous day. On Wednesday, the patient returns to complete 2 hours of technician based testing. On Thursday, the

patient completes 1 hour of psychological testing face-to-face with the provider (no significant clinician interaction beyond "Any problems that would interfere with testing today?"). On Friday, provider spends 2 hours interpreting testing and preparing report, then provider meets with patient for 30 minutes individually to review testing feedback (5-10 minutes) and spends 20-25 minutes discussing how the patient can use that information for insight and/or to improve coping or better manage stressors. Then, with patient's permission, the spouse joins in and the provider, patient and spouse spend another 30 minutes discussing the evaluation and how the spouse and patient can utilize the information to reduce conflict and/or help the patient cope with his difficulties.

Coding:

Monday	90801	For clinical interview
Tuesday	90804 and 96120	For continuation of history and diagnostic information. Documentation must support the psychotherapy services provided. If documentation does not support the psychotherapy services, use of the office visit E&M codes may be more appropriate
Wednesday	96102 with 2 units of service	
Thursday	Use 96101 with 1 unit of service	
Friday	90804 90887	For the patient only encounter For spouse attendance and explanation of results

Diagnostic Interview: An Example of a Bundled Code

According to the CPT, bundled within the diagnostic interview CPT code **90801** is pre-service work, intra-service work, and post-service work.

Pre-service work depends on how the patient was referred, but at a minimum may include a telephone discussion with the referring provider (e.g. physician, supervisor) and may include review of records from the referral source and lab or consultation reports.

Intra-service work may include:

- Complete psychiatric history including presenting illness, past history, family history, and complete mental status exam

- Selected physical exam
- Arrangements for laboratory tests as appropriate
- Establishment of a definitive diagnosis or a narrow enough differential diagnosis to warrant a treatment plan
- Decisions concerning need for degree of supervision (e.g. hospitalization)
- Patient counseling regarding diagnosis and options for treatment

Post-service work may include:

- Arranging further studies and further care
- Preparing a report or discussion with referral source
- Arranging to obtain additional information
- Documenting in the chart
- Communicating as required with the patient and/or family after results of studies are known or due to side effects of an instituted treatment

It is important to note that gathering collateral information and reviewing records are bundled within the CPT 90801. However, in certain circumstances where the time spent gathering collateral information exceeds 60 minutes, the modifier 22 is used. The diagnostic interview is then coded E&M **99499** and CPT **90801-22**.

In some cases a patient may arrive late for their scheduled initial diagnostic assessment and the intake is only partially completed. In this case, code the appropriate E&M code **99201-99202**. When they return to complete the diagnostic interview, code E&M **99499** with the CPT code **90801** for the diagnostic interview.

See documentation example in Appendix D. The S should begin with "See my notes from (DATE)…." Give a brief synopsis, do an interval history and see if there have been any changes.

90801 can be used more than once for the same patient, but the documentation must clearly reflect that a second diagnostic interview was conducted.

Example:

A patient is initially seen by a social worker who performs a diagnostic interview, develops a treatment plan for counseling services with the patient and also refers the patient to a psychiatrist. Ten days later, the psychiatrist sees the same patient, conducts a second diagnostic interview including a review of the patient's history and symptoms. The psychiatrist documents his/her diagnostic interview in his/her usual manner and

uses E&M **99499** and **90801** codes. The same rule applies if a social worker consults psychology for a second opinion on the primary diagnosis. The psychologist does his/her own diagnostic interview, e.g., review of history and symptoms coded **99499** and **90801** and then schedules patient to return for psychological testing at a later date.

Psychiatric Evaluation of Records

Psychiatric evaluation of records in this handbook is distinctly different from the Version 1.0 Air Force Guidelines for Standardized Workload Capture discussion of record review. Record reviews are not captured with 90885 in physical medicine, but are captured in mental health when the procedure performed meets the following definition for psychiatric evaluation of records. The CPT code **90885** is defined as the psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests and other accumulated data for medical diagnostic purposes. This code is used when a mental health provider is asked to do a review of records for psychiatric evaluation without direct patient contact. It may also be employed as part of an overall evaluation of a patient's psychiatric illness or suspected psychiatric illness, to aid in the diagnosis and/or treatment plan without direct patient contact. A written psychiatric opinion is rendered. This professional activity is bundled as part of the initial diagnostic interview and therapy codes and **will not be coded** if codes in the **90801-90857** range are used. Evaluation of all available data is always part of treatment. The code **90885** is for paper review of the patient, without seeing or treating the patient, to make a diagnosis. This information is reported as a non-count encounter in the "B" MEPRS.

Example:

Use E&M **99499** and CPT **90885** codes for a comprehensive record review with documentation conducted as part of a security clearance evaluation or a Medical Evaluation Board (MEB) in which there is a medical opinion rendered and no direct patient contact.

CPT Code 90882 versus CPT Code 90887

CPT code **90882** is defined as an environmental intervention for medical management on the patient's behalf with agencies, employers or institutions (e.g. advising a Commander to change something about the patient's environment to aid in managing the condition). This code is used when the provider intervenes in the environment on behalf of the patient. This follows the patient's assessment which identified environmental factors that exacerbated the patient's condition.

An example might be a provider meeting with a patient's supervisor to discuss work strategies that might help the patient better manage his/her chronic pain condition (e.g. pacing activities).

CPT code **90887** is defined as the interpretation or explanation of results of psychiatric, other medical examinations and procedures, other accumulated data to family or other responsible persons, or advising them how to assist the patient. This code is used when examinations or procedures must be explained to the patient's family and/or employer in order to obtain their permission, participation, and/or support for the patient's treatment. An example might be the Treatment Team Meeting conducted in the ADAPT Program.

Exceptional Family Member Program (EFMP)/ Special Needs Identification and Assignment Coordination (SNIAC)

Current Special Needs Policy states that the MTF appoints the Special Needs Coordinator (SNC) from among the assigned clinical officers at the facility. If the SNC is a mental health provider the following guidelines/scenarios apply but are not all inclusive.

The Exceptional Family Member Program (EFMP) / Special Needs Identification and Assignment Coordination (SNIAC) process can include both administrative and clinical functions performed by both the clinical provider and technician or civilian equivalent. Only encounters meeting the criteria for a clinical encounter will be coded to the BFXX MEPRS. All other administrative functions (record reviews, telephone consults and tech time) will be recorded in FAZN MEPRS.

Example A:

The SNC, a credentialed mental health provider, receives a referral from a Primary Care Manager (PCM) to evaluate a Family Member/Husband (FM/H) for EFMP/SNIAC enrollment eligibility. The identified diagnosis is diabetes, and the PCM additionally requests support to the FM/H on stress management to assist in managing the diabetes.

The SNC reviews the medical records, patient encounter histories, and consults with the PCM regarding prognosis and treatment recommendations. The SNC interviews the FM/H, and determines that the patient does meet EFMP enrollment criteria. She explains the program to the sponsor, initiates the Q-code initiation letter to Air Force Personnel Center (AFPC). The Family Member Relocation Clearance Coordinator (FMRCC) assists by establishing a Special Needs Assignment Coordination (SNAC) file and entering the case into the electronic Special Needs database. The SNC documents a problem focused history, a problem focused psychiatric exam with straightforward

medical decision making in the outpatient medical record, the SNAC file, and reviews the electronic case entering comments as needed.

The SNC discusses with the patient the PCM's referral for stress management and confirms the FM/H's interest in receiving services. A separate appointment is made to conduct an assessment and establish a treatment plan.

The FMRCC documents time spent under MEPRS, but does not code since there was no direct clinical care with the patient. In subsequent stress management appointments, the SNC codes according to mental health coding guidelines separate from the SNIAC encounters.

The administrative functions for this encounter: review/t-con time goes in FAZN MEPRS.

Interviews with no immediate mental health needs and no history found in record are coded E&M **99201** and the appropriate diagnosis code.

NOTE: these scenarios are coded to the patient(s) with the special need(s).

Example B:

A First Sergeant informs an ADM that pursuant to recent crisis calls, the FM/S is likely to meet EFMP/SNIAC enrollment criteria and recommends evaluation by the SNC, also a credentialed mental health provider. A full diagnostic appointment is scheduled.

The 16-year-old son arrives to the appointment with his parents and consents to evaluation. In separate interviews with the parents (30 min) and then with the son the SNC performs a detailed history, detailed psychiatric exam and medical decision making of low complexity (30 min) and determines the need for further psychological testing and continued assessment. The SNC obtains consent to discuss school performance with the school counselor and principal, and obtains a signed release form to obtain documentation from a TRICARE mental health provider whom the family saw for three sessions approximately six months ago. The patient returns for follow-up with the SNC to complete the diagnostic assessment. These activities were performed in the BF MEPRS and it is not necessary to schedule another appointment for EFMP/SNIAC enrollment purposes because the provider has first hand knowledge of the diagnosis. However additional review of other family members' medical records to support the SNAC file is captured in the FAZN MEPRS.

After reviewing the obtained information, to include results of psychological testing and completing another diagnostic interview, the SNC determines there are both a mental health diagnosis and a learning impairment for which the school is developing an Individualized Education Program (IEP).

The SNC codes the first encounter with the 16 year-old as E&M **99203** with the appropriate diagnosis code. This includes the records and previous testing results reviews, and teleconferences. The SNC codes the second encounter in which they completed the diagnostic interview and reviewed the results of the psychological testing as **90801**. Documentation should include a statement in the "S" of the SOAP note "See my notes from (DATE)," give a brief synopsis, do an interval history and see if there have been any changes.

The FMRCC meets with the family to explain the relocation process since the sponsor has been identified for relocation within the next six months, and continues to consult with the family on forms and processes thru the relocation process. For each interaction, the FRMCC captures time spent in the FAZN MEPRS and informs the SNC about the family's expressed concerns to support the Facility Determination Inquiry (FDI) process.

Example C:

The SNC meets with a family of four for a travel screening interview. He identifies a mental health history for the FM/H and meets with the husband separately for about 10 minutes during the relocation clearance appointment. During this time, the SNC performs a problem focused history, a problem focused psychiatric exam and straightforward medical decision making discussing with the patient which medications have been used over the past year, how many sessions the husband has attended with the off-base psychologist, and assesses the patient's compliance with treatment recommendations provided in the medical record. The other family members proceed with the family member relocation clearance process and have no clinical issues identified. The SNC summarizes this information on the AF 1466 and staffs the case with the SGH to recommend forwarding the information to the gaining base for determination of travel recommendations. The SNC also explains to the FM/H that he meets the requirements for mandatory enrollment of the sponsor in EFMP and obtains consent to hold a separate appointment with the sponsor to initiate the enrollment.

The SNC codes E&M **99201** with the appropriate diagnosis code for the time spent interviewing the patient and reviewing records, and for consulting with other medical providers.

The SNC documents and codes E&M **99499** and ICD-9-CM **V68.0X** issue of medical certificate for the remaining three family members.

Interdisciplinary Collaboration

Some patients may have services provided by more than one clinic specialty and/or may include other members of the patient's family during an encounter. These encounters may be provided as Shared Medical Appointments, Overseas Clearances, multiservice appointments, and Drop in Group Medical Appointments (DIGMAs).

In these encounters both the mental health provider and the physical medicine provider must document and code the encounter. The mental health provider will typically need to walk-in the patients to their clinic in AHLTA at the conclusion of the encounter (coded as Medical Team Conference E&M **99366-68**). As always, documentation must clearly support the code used for the encounter

Example A:

Clinical Case Conference: Patient not present. Provider presents a detailed review of a complex case to a panel of mental health professionals from various disciplines (e.g., social work, nursing, psychiatry, psychology and substance abuse counselors) for feedback and ideas on treatment planning.

Example B:

Clinical Case Conference: Patient not present. Provider presents a detailed review of a complex case to a panel of mental health professionals from various disciplines, e.g., social work, nursing, psychiatry, psychology and substance abuse counselors, for purposes of coordination because patient is seeing 2+ providers within the clinic for different aspects of treatment.

Example C:

High Risk Meeting: Patient not present. Provider presents a detailed review of a patient with significant risk issues for purpose of coordinating care between on-call providers, clinic technicians and other providers who may have additional information/history or have contact with patient or patient's family.

These examples do not fit coding criteria. These are documented for clinical care purposes, but are not coded.

Residency Coding

In work centers in which residents are providing clinical care under the supervision of a credentialed and licensed provider, the patient appointment goes into AHLTA under the resident (as the GME role) and the staff/provider is entered as a supervising provider in AHLTA and must co-sign the encounter in the AHLTA cosign module. When the supervising provider is present during the critical and key portions of the encounter, the supervising provider is listed as the primary and the resident is listed as the secondary provider (in the GME role).

Documentation

All clinical encounters must be documented. Documentation must support the code selected; therefore, documentation requirements depend on the nature of the encounter. In general, documentation includes the time spent, what was discussed, follow-up plan, and disposition. Documentation indicates why the time was necessary, what occurred during that time, and how much time was spent. For therapy, the time that face-to-face therapy started and ended should be documented because the therapy codes are time based. Time spent conducting the E&M component is not included in the therapy time. (see Appendix D for specific documentation requirements).

Documentation for diagnostic assessment and psychotherapy (both individual and group) should be structured in the S-O-A-P-P format (see Appendix D). This format includes the Subjective (S), which reflects what was discussed and the history, the Objective (O), which includes the examination (mental status and screening), the Assessment (A), which includes the diagnoses and other medical decisions/impressions, Plan (P), which includes treatment issues (e.g., homework, referrals, and follow up plan), and Prevention (P) (e.g. exercise).

Auditing Records

Coding auditors must be allowed to view the mental health records (e.g. copy relevant sections for them to view in the mental health clinic or have them view the records within the mental health clinics).

Medical Expense Performance Reporting System

Just as standardized coding of clinical encounters helps the AF Medical Service better account for workload and productivity, common MEPRS coding practices will help the AF

Medical Service account for the costs, manpower, and work associated with various medical cost centers. Accurate MEPRS coding should lead to a closer match between the manning and budget allocated to a clinic and its actual requirements. (see Appendix E for specific guidance).

GENERAL MENTAL HEALTH - AMBULATORY

This section describes general mental health services. E&M and CPT codes are listed for each clinical service. Clinicians must use ICD-9-CM codes for data entry purposes. Unique diagnostic issues are highlighted where appropriate.

Diagnostic Interview

The diagnostic interview includes a comprehensive psychosocial assessment. The purpose of the interview is to develop a good case formulation to make an appropriate diagnosis, and begin treatment planning. Providers assess the presenting complaint, the history of present illness, family and social history and a review of habits (e.g. substance use, exercise). A mental status exam is performed and neurovegetative symptoms are assessed. Co-morbid medical conditions, allergies, pain problems and current medications, as well as past medical history are documented. Collateral information from family members or other responsible persons (e.g. First Sergeant) may also be obtained. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. For prescribing providers, this may also include pharmacotherapy and labs ordered as indicated. Typically, this activity lasts 60-120 minutes.

Coded with E&M **99499** and CPT **90801** (adults) or **90802** (typically used with children who, due to young age or developmental dysfunction are unable to communicate clinical symptoms or needs. Case conceptualization is primarily based on interaction with the child).

Example:

A comprehensive evaluation of a 24-year-old active duty member referred by his primary care provider for depressive symptoms is performed in the outpatient mental health clinic. A medical record review and consultation with the referring provider is also conducted. This encounter is coded E&M **99499** and **90801**.

Psychological Testing

Results can be scored by a computer, technician, or clinician. Interpretation of psychological testing is performed by a clinician. A report is written for the mental health record or for the referring provider as applicable. The overall time can vary from one to eight or more hours depending on the psychological instruments used. Some commonly used instruments include: MMPI-II, MCMI-III, and WAIS-III. Administration time of each test also varies: MMPI-II-approximately 90 minutes, MCMI-III-approximately 60 minutes, and WAIS-III-approximately

two to three hours. Review of the test, scoring, interpretation of the results, writing the report, and feedback to the patient can take approximately one to four hours.

Coded with E&M **99499** and CPT **96101**, **96102**, (one unit per hour) depending on whether the testing is conducted by a psychologist, a technician or a computer.

Example:

A 27-year-old active duty member is being evaluated for possible behavioral contributors to her persistent chronic fatigue. Her medical work-up was within normal limits, and she denies any significant problems with mood or stress, but is extremely pleasant and cooperative and is interested in completing a full psychological evaluation. The psychologist administers psychological testing to include the MMPI-II, WAIS-III, BDI-II, BAI, and SF-36 to aid in the diagnostic assessment. The face to face administration of the WAIS-III, takes two hours. The MMPI-II, BDI, BAI and SF-36 (computer/pen-and-paper instruments) take four hours. The psychologist also conducts a comprehensive diagnostic interview. This scenario is coded E&M **99499** and CPT **90801** (primary CPT) and CPT **96101** x2 units of service, CPT **96103.**

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes.

Individual Psychotherapy

Individual psychotherapy refers to individual treatment that includes insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved psychosocial functioning. A multi-axial and differential diagnosis is performed, and follow-up plans (i.e. disposition) are identified. Assessment of risk status and a mental status examination is also performed. Brief psychological screening instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2), but are not coded separately. Education, discussion about stressors, identification of cognitive distortions and/or support may also occur.

Coded depending on the length of the appointment E&M **99499** and CPT **90804**, **90806**, or **90808**. Coded CPT **90810**, **90812**, or **90814** if working with a young child or a child with significant verbal difficulties.

Example:

A 32-year-old female family member who is being treated for Major Depressive Disorder is seen for her second individual psychotherapy appointment. She is taught cognitive restructuring in this 30 minute face-to-face individual psychotherapy visit. She is also given the homework assignment to monitor one situation in the next week in which she found herself becoming more upset than she'd like to be and to document that situation according to the skill she was taught. This encounter is coded E&M **99499** and CPT **90804**.

Individual Psychotherapy with Medical Management

This refers to individual treatment that includes insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved psychosocial functioning. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. An assessment of risk status and a mental status examination are performed. Brief psychological screening instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2). Evaluation of medication compliance and side effects, review of medications, and/or effectiveness of medication are also performed. Education, discussion about stressors, identification of cognitive distortions, and/or support may also occur

Coded depending on the length of the appointment E&M **99499** and CPT **90805**, **90807**, or **90809**. Coded CPT **90811**, **90813**, or **90815** if working with a child.

Example:

A 32-year-old female family member who is being treated for Major Depressive Disorder is seen for her second individual psychotherapy appointment with a psychiatrist. She is taught cognitive restructuring in this 50 minute face-to-face individual psychotherapy visit. She is also given the homework assignment to monitor one situation in the next week in which she found herself becoming more upset than she'd like to be and to document that situation according to the skill she was taught. Her responsiveness to the recently prescribed antidepressant medication Prozac is assessed and any compliance and side effect issues and/or concerns are addressed. This encounter is coded E&M **99499** and CPT **90807**.

Pharmacologic Management without Psychotherapy

Compliance with and side effects of existing psychotropic prescription(s) is assessed and clinical issues around medication use are discussed. The dose is adjusted as needed, or agents are changed after discussing risks, benefits, and/or indications of the medication. Labs are ordered as indicated. If psychotherapy is provided, it is minimal in comparison to time spent discussing medications.

Coded E&M **99499** and CPT **90862**.

Example:

A 32-year-old female family member who is being treated for Major Depressive Disorder is seen by a prescribing provider for his third medication management session. He has elected not to receive psychotherapy at this time and prefers pharmacotherapy only. His responsiveness to the recently prescribed antidepressant medication Prozac is assessed and any compliance and side effect issues and/or concerns are also addressed. General cognitive coping skills are assessed and discussed. This encounter is coded E&M **99499** and CPT **90862**

In some cases pharmacotherapy is provided for tobacco cessation groups. A prescribing provider attends the group meetings and discusses pharmacologic treatment options and mechanism of action, the risks, benefits, and contraindications of each (about 15-20 minutes). Encounter documentation must reflect the criteria. *(See documentation example in Appendix D.)* The prescribing provider then reviews each patient's medical record and determines the appropriateness of receiving tobacco cessation medications (restricted to psychotrophic medications: e.g., Zyban).

Coded E&M **99499** and CPT **90862.**

Biofeedback

Biofeedback requires specialized training and involves both assessment and treatment using biofeedback equipment. It may or may not include psychotherapy. Biofeedback may be conducted in both inpatient and outpatient settings.

Coded E&M **99499** and CPT **90875** or **90876** depending on duration and includes psychotherapy. Coded **90911** for fecal incontinence biofeedback.

Example A:

A 43-year-old female family member with migraine headaches is seen for her third biofeedback-assisted relaxation in which she is utilizing thermal biofeedback in conjunction with imagery. The provider is present throughout the duration of the 50-minute appointment. This encounter is coded E&M **99499** and CPT **90876.**

Example B:

Same as above, but provider sees the patient briefly prior to biofeedback to assess current neurovegetative symptoms, review purpose of biofeedback and answer questions. A technician who has previously been supervised and observed doing biofeedback performs the biofeedback with the patient. This biofeedback session with the technician is coded E&M **99211**.

Example C:

Same as above, except provider does not see patient that day (patient has been stable, is coming in for third or fourth biofeedback session, sees the provider on a different day for associated counseling. Same technician as above performs biofeedback session. This biofeedback session with the technician is coded E&M **99211**.

Hypnotherapy

Hypnotherapy is a specialized form of psychotherapy which requires specific training, credentialing, and certification.

Coded E&M **99499** and CPT **90880**.

Example A:

A 48-year-old female family member with a history of physical abuse in childhood and recurrent Major Depressive Disorder is seen for her second appointment. She participates in a session where hynoptherapy is the primary mode of treatment with a psychologist with special certification in hypnotherapy. This session is coded E&M **99499** and CPT **90880**.

Example B:

Same patient as above working with a psychologist with special certification in hypnotherapy, but the hypnotherapy portion is 15-20 minutes and 40-45 minutes are spent discussing cognitive restructuring strategies and exposure techniques to decrease the negative reaction to sights/sounds which remind the patient of the childhood abuse.

If hypnotherapy is provided with psychotherapy, only CPT **90880** is reported for that session.

Family Psychotherapy

Family members may also be involved with a patient's care. For example, family members may be taught skills to improve communication in the family. Family psychotherapy can be done in an individual or group setting.

Coded E&M **99499** and CPT **90846** for family psychotherapy without the patient present, E&M **99499** and CPT **90847** for family psychotherapy with the patient present, and E&M **99499** and CPT **90849** for multiple-family group psychotherapy.

Example:

A dual active duty couple and their 16-year-old daughter are seen for two sessions to work on parent-adolescent conflict issues. The teen is the identified patient and the family meeting is an adjunction to the teen's on-going individual counseling. Problem-solving and communication techniques are discussed and assigned as homework. These sessions are coded with E&M **99499** and CPT **90847**. The clinical encounter is documented in all three records; however, only the teen's encounter is coded.

Marital Therapy

Initial diagnostic interviews are conducted for both partners to identify goals for treatment and determine a multi-axial diagnosis. Treatment sessions may include addressing couple conflict issues and providing assistance with communication and conflict resolution skills. Diagnostic and/or screening psychological instruments may also be used during the assessment and/or to track treatment progress.

Coded E&M **99499** and CPT **90801** for the first appointment and E&M **99499** and CPT **90847** for subsequent treatment sessions.

Example A:

Per provider preference and training, both the husband and wife are seen separately (individually) for diagnostic interviews and to get their in-depth perspective on the problems within the marriage. Subsequent sessions are attended as a couple. The initial individual meetings are coded E&M **99499** and CPT **90801** for both patients. Subsequent couples meetings are coded E&M **99499** and CPT **90847** for one spouse; other spouse is documented separately and coded E&M **99499**.

Example B:

Per provider preference and training, the husband and wife are seen together from the beginning including a lengthy initial session. This initial session is when the history and symptoms of both the husband and wife are reviewed as well as the history of the relationship and dynamics of the problems from the perspective of the husband and the wife. Initial individual meetings are coded E&M **99499** and CPT **90801** for both patients. Subsequent couples meetings are code E&M **99499** and CPT **90847** for one spouse; other spouse is documented separately and coded E&M **99499**.

Group Psychotherapy (includes psycho-educational, and process and/or support groups)

Psychotherapy may be conducted with several patients in a group setting. The personal dynamics of an individual may be discussed by the group and the dynamics of the group may be explored at the same time. Interpersonal interactions, skill-building, and support, are examples of the processes in group settings. Interventions may be focused on skill-building and subsequent behavioral change. The groups may vary in duration typically from 60 to 120 minutes.

Coded E&M **99499** and CPT **90853**.

Example:

A four session psycho-educational group taught by a provider for managing depression, called Depression Management, is taught in the outpatient mental health clinic. It involves individual level discussion at each session with goal setting, behavioral activation, and cognitive restructuring. Individuals are assessed briefly during the course of the group for overall mood and complete brief risk status assessments prior to the start of each appointment. Each 90-minute session is coded E&M **99499** and CPT **90853**.

Healthy Living Program

Individuals who do not meet the Air Force fitness standards as evidenced by a marginal score or lower on the AF Fitness Test attend the Healthy Living Program group. There is no individual diagnostic interview prior to attending this group. The mental health portion is a 90-minute psycho-educational group targeting exercise and nutritional behavioral change. The biopsychosocial factors of health and fitness, and strategies of successful health behavior change are discussed. Group discussion and completion of a self-assessment tool for enhancement of motivation for fitness is conducted and skills for setting reasonable and

sustainable goals are addressed on an individual level. Group participants are assisted in developing short and long term goals and a 2-week plan to progress toward goals. Skills to maintain behavior change are taught and a relapse prevention plan is developed.

Coded E&M **99412** (privileged provider) or **99211** (technician) and an ICD-9-CM **V65.41**, exercise counseling.

Example:

A 45-year-old active duty member fails the fitness test with a score of 68. He attends the Healthy Living Program group led by the privileged provider (e.g., clinical psychologist, social worker, psychiatrist, etc) and states he has difficulty finding time to exercise and thus performed poorly on the mile and a half run. He sets a goal to increase his exercise behavior and during the workshop learns how to make a reasonable, realistic goal. He leaves the group with a clearly stated goal and a clear understanding of how to meet that goal and various relapse-prevention strategies. This 60-minute encounter is coded E&M **99412** and ICD-9-CM **V65.41**, exercise counseling.

Environmental Intervention Commander, First Sergeant, and/or Supervisor

This intervention is usually to discuss job limitations and/or environmental changes that would help the patient in managing their mental health condition (e.g. shift changes). This session may include a discussion of duty restriction, a safety concern or other patient concerns. It is common for this intervention to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example:

A 29 year old active duty member with chronic pain due to degenerative disk disease reports that she was removed from the flight line due to her “back pain” and now sits at a desk all day. She is working on cognitive-behavioral strategies for pain management and would like to return to the flight line. The psychologist meets with the Commander to discuss the benefits of returning to the flight line (e.g. behavioral activation and pacing activities) in this patient’s treatment/success at managing the chronic pain. This meeting is coded E&M **99499** and CPT **90882**.

Interpretation and/or Explanation of Results with Family Members, and/or other Responsible Persons or Advising them on How to Assist the Patient

These meetings involve others in the therapy/treatment process to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

A psychologist meets with a patient with chronic pain and his spouse to discuss ways in which the spouse may help the patient manage the pain more effectively. This meeting is coded E&M **99499** and CPT **90887**.

Preparation of a Report for other Physicians, Agencies, or Insurance Carriers-non-legal Purposes

Reports may be requested by patients for outside agencies, insurance carriers and/or other outside health care professionals for non-legal purposes. These may include summary of care statements and/or statements of medical conditions. It excludes MEBs, Command-Directed Evaluations (CDEs), overseas clearances, and consultation responses.

Coded E&M **99499** and CPT **90889**.

Example:

A 33-year-old female family member has received treatment for Posttraumatic-Stress Disorder in a mental health clinic. She and her husband are PCSing, and she plans to continue her mental health treatment with a civilian provider at their new location. She asks for a report summarizing her treatment to date to give to her new provider. Preparation of this report is documented in AHLTA and coded E&M **99499** and CPT **90889**.

Medical Team Conferences

A medical team conference is with an interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (the patient is not present). The conference can is for the formulation of care for a specific patient and last approximately 30-60 minutes.

Coded E&M **99366** (face-to-face, 30 min or more, non-physician), **99367** (no face-to-face, 30 min or more, physician) or **99368** (no face-to-face, 30 min or more, non-physician) with no CPT code.

Example:

A 42-year-old MSgt with chronic migraine headaches has been seen by Neurology and is followed in the outpatient mental health clinic. The patient is frequently scheduling medical appointments in Neurology and Primary Care. He has been prescribed narcotic pain medications for his condition, which he now wishes to discontinue. The psychologist schedules a 60-minute medical team conference to discuss with the Neurologist and Primary Care Physician the patient's diagnosis, treatment to date, and plan for tapering of the medication in conjunction with cognitive-behavioral treatment. In this example, each provider may code this encounter separately, but must document in separate notes (in S-O-A-P-P format) the nature of their work during this medical team conference. This conference is coded E&M **99368** for the psychologist.

Walk-ins-Diagnostic Interview

Walk-ins are typically unscheduled visits to the clinic in which a patient is seen for a complete diagnostic assessment. Coding and documentation rules with regard to Diagnostic Interview apply in this case.

Coded E&M **99499** and CPT **90801 or 90802**.

Example A:

A 26-year-old SSgt walks in to the outpatient mental health clinic and requests to be seen. She is tearful and complains of depressive symptoms. She is seen by a provider for a diagnostic interview and is determined to not be at imminent or other risk of self-harm or harm to others, but she is highly motivated to begin treatment and feels she overcame a significant barrier by walking into the clinic that day. This encounter is coded E&M **99499** and CPT **90801**.

Example B:

A 22-year-old SrA walks into the outpatient mental health clinic and requests to be seen. He is initially seen by a mental health technician and states that he is very stressed about a work situation and hasn't been sleeping well. The patient reports some passive suicidal ideation, but denies active plans or intent. The technician reviews the case with the on-call provider who sees the patient to review his symptoms and complete a risk assessment. The provider continues into a comprehensive review of the patient's history

completing a diagnostic interview. The provider reviews treatment options with the patient, they agree to an initial plan and a follow-up appointment is made. This encounter is coded as E&M **99499** and CPT **90801**. The technician documents his/her interaction with the patient in AHLTA S/O. The provider completes the usual documentation for a diagnostic interview in the same note began by technician. The technician is listed as the secondary provider (paraprofessional).

Walk-ins-Crisis Assessment and/or Intervention

Walk-ins may be problem-focused assessments for crisis issues and/or safety assessments. The evaluation and disposition of the patient is usually focused in nature and is approximately 20 to 30 minutes in duration. The codes for this encounter may include E&M **96152,** health and behavior, or psychiatric codes. Use ICD-9-CM **V71.89** or the appropriate diagnostic code for the situation presented.

Example A:

A 26-year-old active duty member walks into the outpatient mental health clinic and requests to be seen. She stated she is thinking of harming herself and does not feel safe. The provider completes a single system psychiatric exam worksheet, with expanded problem focused history and exam, straightforward decision making. She is seen for approximately 25 minutes by a provider for a focused risk assessment. She consents to inpatient psychiatric hospitalization and awaits transportation to a civilian facility. This encounter is coded E&M **99202**.

Example B:

A 24-year-old active duty member walks into an outpatient mental health clinic and requests to be seen. His presenting compliant is that he just returned from deployment one week before and now his wife of three years says she wants a divorce. They argued most of the previous night, he stated they yelled at each other several times and he "barely" restrained himself from hitting her. Member now suspects his wife had an affair while he was deployed, but has no specific information. Member reported being alternately depressed and very angry. Patient reported some risk issues (some thoughts of running his car into a tree, and if she did have an affair, has thoughts of beating up the partner, but in both cases denied that he was planning or intending to do either). After calming the patient and having a detailed discussion with him about appropriate safety plans, they develop a safety plan which includes the provider contacting 1st Sgt to recommend that member be moved to the dorms for safety reasons (prevent a domestic incident). The provider also discusses ways to help the patient not become violent. Provider completes a comprehensive single system psychiatric exam and a

comprehensive history. This encounter is coded as E&M **99204** for moderate complexity decision making and coordination with other agencies.

Example C:

A 22-year-old female active duty member walks into an outpatient mental health clinic and requests to be seen. Her presenting compliant is poor sleep, low appetite, fatigue feeling "numbed out" for the past two months, increased mistakes at work (was removed from flight line duties last week because she contributed to mis-coordination between maintenance teams resulting in a dropped engine) and later in interview acknowledged she starting hearing voices about six weeks before telling her to hurt herself because she is "ugly" and "nobody cares." She disclosed that about two months before she went through a relationship breakup and also found out her parents were divorcing. She denied wanting to hurt herself, denied intent or plan to suicide, but stated that it was getting harder and harder to "fight off" the voices and sometimes thinks it would be easier to "just give in" and cut herself like the voices tell her. She denies previous mental health treatment, but reported a history of cutting as a teen, illegal drug use prior to military, and two blood relatives with significant psychiatric care histories including a cousin who is "some sort of schizo." Patient initially refuses hospitalization because she fears losing her military career, but after discussion about her increased risks of hurting herself or others, she agrees to inpatient care. Provider coordinates with TRICARE hospital to obtain a psychiatric bed and with member's squadron to assist in getting an overnight bag for patient. Provider completed a comprehensive psychiatric exam and a comprehensive history of the chief complaint, but didn't review other domains of patient's history (childhood, medical, medications, academic, work history, etc) needed for a comprehensive diagnostic interview (90801). This encounter is code E&M **99205** for high complexity decision making and coordination with other agencies.

Security Clearance-Record Review Only

This examination involves a comprehensive review of record for mental health concerns that may need to be further evaluated in a problem-focused or diagnostic interview appointment. The patient is not seen face-to-face; record review only for diagnostic purposes.

Coded E&M **99499** and CPT **90885** and ICD-9-CM **V68.0X**, issue medical certificate.

Security Clearance-Problem-Focused Assessment and/or Intervention

Security Clearance record reviews may precipitate a problem-focused assessment depending on the presence of mental health concerns. This includes approximately 20-30 minutes of focused information gathering and intervention as appropriate.

The codes for this encounter may include E&M or psychiatric codes. If a specific diagnosis is not identified then use ICD-9-CM V68.0X, issue medical certificate.

Example:

A record review for security clearance revealed a Family Advocacy incident three years prior. The active duty member is scheduled for an appointment to discuss that incident, any treatment received and current relevant issues. The provider completes a problem focused psychiatric exam, with expanded problem focused history, and straightforward decision making. This scenario is coded E&M 99201 and ICD-9-CM V68.0X, issue medical certificate.

Security Clearance-Diagnostic Interview

Security Clearance record reviews may require a complete diagnostic assessment depending on the presence of mental health concerns. Coding and documentation rules with regard to Diagnostic Interview apply in this case.

Coded E&M 99499 and CPT 90801. If another ICD-9-CM code is not identified then use ICD-9-CM V68.0X, issue medical certificate.

Example:

A security clearance record review of an active duty member received reveals treatment for depression by their PCM within the past five years with no indication of issues resolved. The member is brought in and reports current depressive symptoms, which necessitates a complete diagnostic evaluation. This scenario is coded E&M 99499 and CPT 90801.

Evaluation for Surgery in Outpatient Setting

These medical consults request clinical evaluation to identify any mental disorders which may contraindicate or complicate a patient's participation in a surgical intervention such as Gastric Bypass, Transplants etc. The evaluation includes a diagnostic interview, a

comprehensive medical record review, and may include psychological testing. A consultation response is sent to the requesting provider.

Coded E&M **99499** and CPT **90801** (diagnostic interview) and can include the additional CPT code **96101-59** -psychological testing as appropriate.

Example:

A 45 year old female family member with a long history of obesity undergoes a psychiatric evaluation prior to Gastric Bypass surgery as a prerequisite for the surgery. The purpose of the evaluation is to identify any mental disorders which may be contraindications or complicate a patient's post-surgery compliance. This evaluation includes a comprehensive review of the patient's three volumes of her medical record (approximately 60 minutes) and a comprehensive report to the requesting provider (approximately 60 minutes). No psychological testing is completed. This scenario is coded E&M **99499** and CPT **90801-22.** The modifier **-22** was used to represent the additional time spent performing a detailed and comprehensive review of the patient's medical records and preparing a comprehensive consultation response to the requesting provider.

Comprehensive Evaluations (including Command Directed Evaluations, Medical Evaluation Boards, Sanity Boards, and Temporary Disability Retirement List (TDRL)

Comprehensive evaluations can include CDEs, MEB, Sanity Boards, TDRL evaluations, Military Training Instructor/Military Training Leader (MTI/MTL) evaluations, and New Accession Evaluations. These evaluations typically can involve a diagnostic interview, review of the medical record and any psychiatric record, consultation with other providers, collateral interviews, psychological testing, and feedback to the patient and other relevant/requesting (e.g. Commander) parties. A formal report is also written. Depending on the type of evaluation, preparation of the report can range from 1-3 hours for a CDE to 3-5 hours for a Sanity Board. These evaluations can also include medical testimony.

NOTE: Time spent in providing medical testimony will be captured in the appropriate MEPRS code FCGA and not entered into AHLTA.

Coding these services can be done by coding the procedures included in the evaluation and can include the following codes as appropriate: diagnostic interview (CPT **90801**), medical record review (CPT **90885**--only in cases where the patient is not seen) face-to-face, consultations or interviews with collaterals, and psychological testing (CPT **96101**, **96102**, **96103**, **96118**, **96119**, or **96120** as appropriate depending on whether the testing: is conducted by a psychologist, a technician or a computer). Feedback to the patient is coded based on the actual service provided during that appointment. For example, counseling and/or education provided to the patient may be coded using an appropriate E&M or CPT

90804, 90806, 90808 depending on the duration of the encounter. Interpretation or explanation of results to family or other responsible persons (e.g. Commander) can be coded CPT 90887.

Example:

A 37-year-old active duty member who is in the recruiting field is sent for a CDE for outbursts at work, tardiness, seemingly depressed mood and lack of motivation, and a 3-month decrease in his work performance and failure to meet quota. He denies any problems to his supervisor and has been reluctant to pursue mental health services in the past (his supervisor suggested he attend a stress management class). The patient is evaluated for the presence of a mental health condition that appears to be interfering with his work performance. He is seen for a diagnostic interview, psychological testing including the MMPI-II, BDI-II, MCMI-III and BAI. This encounter is coded E&M 99499 and CPT 90801 and 96103.

On a separate day the Commander is given an explanation (face to face) of the results and recommendations. This meeting is coded E&M 99499 and CPT 90887. Telephone feedback to the Commanders are documented but not coded.

On a separate day a 30 minute face-to-face session is held with the patient. The final recommendations of the CDE are reviewed, the testing results are discussed and most of the session is focused on stress management education and discussion of ways the member can better manage his stress as a recruiter. This meeting is coded E&M 99499 and CPT 90804.

Inpatient/Ward Consultations-Initial Assessment

This assessment refers to consultation requests from medical providers regarding evaluation of specific mental health needs and/or assistance in diagnosis and treatment of mental health needs. The assessment may involve review of the outpatient and inpatient record and diagnostic interview, and may also include psychological testing. It may also involve phone communication with the requesting provider.

Coded E&M 99251-99255, consultation, or 99499 and CPT 90801 or 90802.

Example A:

A consultation is requested to assist a patient on the ward in swallowing pills. Psychologist goes to the ward and gathers a problem-focused history, a problem-focused exam with straightforward medical decision making and spends 10 minutes teaching a

brief relaxation exercise while the patient successfully attempts pill swallowing. This encounter is coded E&M **99251.**

Example B:

A consultation is requested by an Obstetrics provider to evaluate a patient for post-partum depression. The mental health provider reviews the patient's medical record, discusses the case with the nursing staff and interviews the patient. The patient is tearful, denies active risk issues, acknowledges fears of being a good mother related to her own chaotic family history and reports some off-and-on tensions within her marriage. The provider counsels the patient regarding emotional reactions of new mothers, ways to reduce her depression/anxiety and healthier communication strategies with her husband. The provider reviews with patient's options for additional care and patient shows interest in counseling and meeting with Family Advocacy home health care nurses. The provider makes referral to Family Advocacy nurses and calls physician to review conclusions and recommendations. The provider documents in the inpatient medical record a detailed history, detailed psychiatric exam and medical decision making of low complexity and writes AHLTA note with consult to TRICARE to schedule follow-up outpatient counseling. This scenario is coded as E&M **99253**.

Example C:

A consultation is requested by a surgeon on the Med-Surge Unit (MSU) inpatient ward for a patient hospitalized post-surgical repair of hernia. This 31-year-old active duty male reported to a nurse that he has been very anxious for many months and it is affecting his work and sleep. The mental health provider responds to consult, reviews medical record and interviews the patient. The provider comprehensively reviews the patient's history and symptoms and concludes that the patient has Panic Disorder without Agoraphobia. The patient is reluctant to engage with outpatient mental health clinic, but does agree to visit with his PCM to consider use of medication. The provider documents the interview in the inpatient chart, calls referring surgeon to review conclusions and recommendations, and writes an AHLTA note detailing diagnostic interview with referral to Family Practice clinic. This scenario is coded E&M **99499** and CPT **90801**.

Inpatient/Ward Consultations Follow-up

These consultations can be similar to an outpatient treatment appointment, and may include insight oriented, behavior modifying and/or supportive counseling. An assessment of risk status and a mental status examination are performed. Evaluation of medication compliance and side effects, review of medications, and effectiveness of medication may

also be performed. Education, discussion about stressors, identification of cognitive distortions, relaxation strategies, and/or support may also be performed.

Coded E&M **99499.** The CPT depends on the duration of the visit and whether evaluation and management services were also provided as follows: **90816** (20-30 min), **90817** (20 to 30 min with E&M services), **90818** (45 to 50 min), **90819** (45 to 50 min with E&M services), **90821** (75 to 80 minutes), **90822** (75 to 80 min with E&M services). Typically when working with young children or children with verbal expressive dysfunction or if other interactive services are included (e.g. interpreter is used), the consultation is coded E&M **99499** and CPT **90823** (20 to 30 min), **90824** (20 to 30 min with E&M services), **90826** (45 to 50 min), **90827** (45 to 50 min with E&M services), **90828** (75 to 80 min), and **90829** (75 to 80 min with E&M services).

Example:

A mental health provider performs a 20-minute follow-up for a patient with pancreatitis who was taught an autogenic relaxation technique the previous day. The provider discusses with patient what was helpful and not helpful and they fine-tune her relaxation procedures. This follow-up is coded E&M **99499** and CPT **90816**.

Emergency Department (ED) Evaluations

During both normal duty hours and after hours, mental health professionals may be asked to provide consultation to the emergency department. This includes an in-person diagnostic interview or triage / risk assessment of the patient with recommendations regarding disposition. Coding and documentation rules with regard to Diagnostic Interview apply in this case.

In cases where the consultation is a telephone consultation only, the ED provider codes and documents the consultation. If the patient is also currently in treatment within the mental health clinic, the mental health provider also documents this telephone contact in the patient's mental health record.

Code with the appropriate E&M or CPT **90801 or 90802** (for children, non-verbal means are primarily used to gather information).

Example A:

An ED provider contacts the mental health on-call provider for consultation regarding a 16-year-old patient brought in by her parents to the ED after they returned home late and found her "drunk." The parents are very worried because their daughter "doesn't drink,"

but has been more withdrawn and mother found a poem the daughter had written about death the week prior. The patient denies any intent or plan, but the ED provider thinks there is "some family stuff going on." The on-call mental health provider reviews the medical record, checks to see if patient has been seeing mental health provider (was not in treatment), talks with the parents, and interviews the teen who thinks the whole thing is "stupid," says she had two beers and fell asleep on the couch watching TV and didn't clean up the beer cans before her parents came home. She stated she would never do suicide because it's cowardly and selfish, and the poem was "an experiment" for a writing class. She has had a falling out with a boyfriend whom her mother never liked; and feels her mother is intrusive and doesn't want to discuss this with her parents. The teen agrees to talk with her school counselor. The provider talks with the parents, reviews the case with the ED physician and complets AHLTA note (focused risk assessment, no risk issues noted, no urgent follow-up needed, notes diagnostic impression of Parent-Child Relational Issue). This consultation is coded E&M **99241-99245**, consultation.

Example B:

An ED provider contacts the mental health on-call provider for consultation with regard to a 38-year-old active duty male who presented to the ED with chest pain. The ED finds no indication of cardiac problems, but patient notes that he is under severe stress, had not been sleeping well for the past three months, and acknowledges thoughts of suicide, but denies any active plan or intent and denies any history of self-harm. The mental health provider reviews the medical record and interviews the patient. The provider spends 45 minutes with the patient and covers not only the current situation, recent symptoms and stressors, but also reviews his work, academic, medical, mental health, relational/social and substance use histories. During the interview the patient acknowledges fleeting, passive suicidal ideation during the previous several days, but states that he wouldn't commit suicide because he had a friend who had committed suicide, and he wouldn't put his friends and family through a similar experience. The provider discusses outpatient follow-up in the mental health clinic and the patient agrees. The provider discusses the case with the ED physician and documents the complete history and risk assessment in AHLTA including multiple axis diagnoses. This consultation is coded E&M **99499** and CPT **90801**.

NEUROPSYCHOLOGY

This section describes the Neuropsychology Clinical Services. E&M CPT codes are also listed for each clinical service. Clinicians must use ICD-9-CM codes for data entry purposes. Unique diagnostic issues are highlighted where appropriate.

Diagnostic Interview

The diagnostic interview includes a comprehensive psychosocial assessment. The purpose of the interview is to develop a good case formulation to make an appropriate diagnosis and begin treatment plan formulation. Providers assess the presenting complaint, the history of present illness, including review of work, academic, medical, family and social histories, and a review of habits (e.g. substance use, exercise). A mental status exam is performed and neurovegetative symptoms are assessed. Co-morbid medical conditions, allergies, and current medications, as well as past medical history are documented. Collateral information from family members or other responsible persons (e.g. First Sergeant) may also be obtained. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Typically, this is a 90-120-minute activity.

Coded with E&M **99499** and CPT **90801** (adults) or **90802** (typically used with children when information is gleaned primarily from interaction with the patient rather than from their verbalizations).

Example:

A 68-year-old female with Parkinson 's disease is referred by her Internal Medicine physician for a neuropsychological evaluation to determine whether her medical condition is impacting her cognitive functioning. The provider reviews the patient's medical, academic and occupational history, as well her current level of adaptive functioning. The patient states that she is still active in church volunteer work and care for herself, but she feels her memory "is going" and notes that several friends have commented on her memory lapses. A comprehensive medical record review is also conducted. The patient agrees to return the following week for 6-8 hours of neuropsychological testing to assess her cognitive functioning and memory skills. The provider documents in AHLTA a complete history with multi-axial diagnoses and notes an R/O of Cognitive Disorder NOS and R/O Age Related Memory Problems. This encounter is coded E&M **99499** and CPT **90801.**

Neuropsychological Test Battery

This test involves a specialized type of psychological assessment designed to test hypotheses and inferences about normal or pathological processes affecting the central nervous system and the resulting psychological and mental functions or dysfunctions. The battery used depends on the referral question and the patient's condition. A typical battery includes 4-8 hours of one-on-one and computer-based or pen-and-paper testing. Commonly used tests include: WAIS-III, WMS-III, Halstead-Reitan Battery (or portions of), verbal learning tests such as HVLT-R or CVLT-II, verbal function tests such as BNT or COWA, and other testing such as MMPI-II, PAI or MCMI-III, and may also include screening instruments such as the Beck Depression Inventory - 2, Geriatric Depression Scale. Administration or portions of administration may be conducted by a provider-extender. Interpretation is performed by a provider. A report is written for the mental health record and/or for the referring provider if applicable. The overall time including interpretation and report writing time can vary from 6 to 10 or more total hours depending on the complexity of the case.

Coded E&M **99499** and CPT **96118, 96119** (one unit of service per hour), or **96120** depending on whether the testing: is conducted by a neuropsychologist, a technician or a computer-based/pen-and-paper instrument.

Example:

A patient with multiple sclerosis mentioned to her neurologist that she is experiencing attention and memory problems and was referred for a neuropsychological evaluation to assess the nature and extent of her cognitive deficits. A comprehensive diagnostic interview was completed by the neurophysiologist. This interview included a review of her history and functioning in several domains including her neurovegetative symptoms and recent stressors. A battery of standardized neuropsychological tests is administered during the course of a full-day evaluation, including two hours of computer-administered/pen-and-paper assessments, and four hours of technician administered testing (two hours spent administering WAIS-III and two hours spent administering Wechsler Memory Scales and Wisconsin Card Sorting Test). The provider spends an additional three hours interpreting all of the testing and writing a report for the neurologist. This encounter would be coded E&M **99499**, and CPT **90801** and **96119 X2** units of service, **96102 x2** units and **96120**.

For a related example of coding for a multi-day psychological evaluation, please see Introduction, page 19.

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes.

Individual Psychotherapy

Individual psychotherapy refers to individual treatment that includes insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved psychosocial functioning. A multi-axial and differential diagnosis is performed, and follow-up plans (i.e. disposition) established. Assessment of risk status and a mental status examination is also performed. Brief psychological screening instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2). Education, discussion about stressors, identification of cognitive distortions and/or support may also occur.

Coded depending on the length of the appointment E&M **99499** and CPT **90804**, **90806**, or **90808**.

Example:

A young patient, recently diagnosed with a grade 2 astrocytoma, is seen for a 50-minute face-to-face individual therapy session to deal with the emotional impact of her diagnosis, and discuss the ways for her to minimize the emotional impact and be more aware of ways the news may be affecting her relationships and occupational functioning. This session is coded E&M **99499** and CPT **90806.**

Environmental Intervention with Commander, First Sergeant, and/or Supervisor

This intervention is usually to discuss job limitations and/or environmental changes that would help the patient in managing his/her mental health condition (e.g. shift changes). This intervention may include a discussion of duty restriction, a safety concern, or other patient concerns. It is also common for an environmental intervention to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example:

An active duty member sustains a mild traumatic brain injury in a bicycle accident while on his way to work. Following neuropsychological screening, the provider meets with the patient's First Sergeant about the patient's current condition, prognosis, and recommended workplace accommodations to help the patient make a more rapid or complete recovery. This meeting is coded E&M **99499** and CPT **90882**.

Interpretation and/or Explanation of Results with Family Members, and/or other Responsible Persons or Advising them on How to Assist the Patient

The involvement of others in the therapy/treatment process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

The provider meets with the parents of an adolescent with a history of intractable seizures (patient not present) to discuss the results of a recent neuropsychological evaluation, and provide recommendations regarding the patient's educational needs, vocational counseling, and social adjustment. This meeting is coded E&M **99499** and CPT **90887**.

Preparation of a Report for other Physicians, Agencies, or Insurance Carriers-non-legal purposes

Reports may be requested by patients for outside agencies, insurance carriers and/or other health care professionals for non-legal purposes. These may include summary of care statements and/or statements of medical conditions.

Coded E&M **99499** and CPT **90889**.

Example:

An active duty member who was referred for and completed a neuropsychological evaluation related to post-concussive syndrome is also followed for a few sessions of individual psychotherapy. At the conclusion of treatment he requests a summary of care statement as he is planning to separate in less than a year and wants specific documentation regarding his injury and recovery. Preparation of this report is coded E&M **99499** and CPT **90889**.

Medical Team Conferences

Medical Team Conferences are with an interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (the patient is not present); they can range from approximately 30-60 minutes.

Coded E&M **99366** (face-to-face, 30 min or more, non-physician), **99367** (no face-to-face, 30 min or more, physician) or **99368** (no face-to-face, 30 min or more, non-physician) with no CPT code.

Example A:

A 42-year-old active duty member who sustained a mild traumatic brain injury in a bicycle accident while on his way to work was seen for a neuropsychological evaluation. He has now been suffering with chronic migraine headaches and has been evaluated by Neurology. The patient is now frequently scheduling medical appointments in Neurology and Primary Care. He has been prescribed narcotic pain medications for his condition, which he now wishes to discontinue. The psychologist schedules a 60-minute Medical Team Conference to discuss with the Neurologist and Primary Care Physician the patient's diagnosis, treatment to date, and plan for follow-up. In this example the provider with the primary responsibility for managing the patient care, (i.e. Neurologist) will document and code this encounter E&M **99367**.

Example B:

A 42-year-old active duty member who sustained a mild traumatic brain injury in a bicycle accident while on his way to work was seen for a neuropsychological evaluation. He now has marital problems (starting marital services in the mental health clinic) and has walked into the mental health clinic twice in the past month related to work crises. The neuropsychologist, the social worker providing marital counseling and other providers within the mental health clinic (including psychiatry, mental health nurse and substance abuse counselors) discuss the case in clinic Case Conference meeting to coordinate care and determine how to best manage the patient, e.g., the neuropsychologist will join the social worker for a few marital sessions to counsel couple on ways to manage his mild cognitive deficits, ways to help him continue to improve and methods to help him better manage his strong emotional reactions. This conference is not coded but is documented in the patient record.

Comprehensive Evaluations (including Command Directed Evaluations, Medical Evaluation Boards, Sanity Boards, and TDRL)

Comprehensive evaluations can include CDE, MEB, Sanity Boards, TDRL evaluations, MTI/MTL evaluations, and New Accession Evaluations. These evaluations typically can involve a diagnostic interview, review of the medical record and any psychiatric record, consultation with other providers, collateral interviews, psychological testing, and feedback to the patient and other relevant/requesting (e.g. Commander) parties. A formal report is also written and depending on the type of evaluation and can range from 1-3 hours for a CDE to 3-5 hours for a Sanity Board for preparation of the report. This can also include medical testimony.

NOTE: Time spent in providing medical testimony will be captured in the appropriate MEPRS code FCGA and not entered into AHLTA.

Coding these services can then be done by coding the procedures included in the evaluation. This can include the following codes as appropriate: diagnostic interview (CPT **90801**), medical record review (CPT **90885**--only in cases where the patient is not seen) face-to-face, consultations or interviews with collaterals and neuropsychological testing (CPT **96116**, **96118**, **96119**, or **96120** as appropriate depending on whether the testing: is conducted by a neuropsychologist, a technician or computer-based/pen-and-paper). Feedback to the patient is coded based on the actual service provided during that appointment. For example, counseling and/or education is provided to the patient it may be coded using an appropriate E&M or CPT **90804**, **90806**, **90808** depending on the duration of the encounter. Interpretation or explanation of results to family or other responsible persons (e.g. Commander) can be coded CPT **90887**.

Example:

A military member who is accused of murdering his wife's male friend claims to have no memory of events that occurred on the night of the crime. Per request from legal, patient is referred to psychiatry for a sanity board. The psychiatrist consulted the neuropsychologist who conducted a comprehensive neuropsychological evaluation to see if neuropsychological testing is more consistent with memory deficits or with malingering. The evaluation consisted of an extensive diagnostic interview, three hours of provider administered testing, two hours of technician administered testing and one hour of pen-and-paper testing. The provider spent an additional three hours interpreting the testing and writing a report to the psychiatrist to include as needed in the sanity board evaluation. This scenario is coded E&M **99499** and CPT **90801**, **96118 x3** units of service, **96119 x2** units of service and **96120**.

CLINICAL HEALTH PSYCHOLOGY (CHP)

This section describes the types of encounters for CHP Clinical Services. These services are similar to general outpatient mental health services; however; there is an emphasis on the biopsychosocial aspects of health and illness and focused work with individuals with physical health concerns and disease states (e.g. chronic pain, diabetes). These services are used to assess and to modify the psychological, behavioral, emotional, cognitive, and social factors that are identified as directly affecting the patient's physiological functioning, disease status, health, and general well-being.

E&M and CPT codes are listed for each clinical service. Clinicians must use ICD-9-CM codes for data entry purposes. Unique diagnostic issues are highlighted where appropriate.

Diagnostic Interview

The diagnostic interview includes a comprehensive psychosocial assessment. The purpose of the interview is to develop a good case formulation to make an appropriate diagnosis, and begin treatment planning. Providers assess the presenting complaint, the history of present illness, family and social history, and a review of habits (e.g. substance use, exercise). A mental status exam is performed and neurovegetative symptoms are assessed. Co-morbid medical conditions, allergies, and current medications, as well as past medical history are documented. Collateral information from family members or other responsible persons (e.g. First Sergeant) may also be obtained. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Typically, this interview is a 90-120 minute activity.

Coded with E&M **99499** and CPT **90801** (adults) or **90802** (typically used with children due to interactive nature).

Example:

A patient with Fibromyalgia is referred by her primary care provider for assistance with cognitive behavioral strategies for pain management. She is seen for a diagnostic interview. A record review is also conducted. A report is sent back to the referring provider. This scenario is coded E&M **99499** and CPT **90801.**

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes.

Individual Psychotherapy

Individual psychotherapy includes insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved psychosocial functioning. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Assessment of risk status and a mental status examination is performed. Brief psychological screening instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2).

Coded depending on the length of the appointment E&M **99499** and CPT **90804**, **90806**, or **90808**.

Example:

An active duty member with tension headaches is seen for a 50-minute individual therapy session for pain education and goal setting. This encounter is coded E&M **99499** and CPT **90806.**

Biofeedback

Requires specialized training and involves both assessment and treatment using biofeedback equipment. It may or may not include psychotherapy. Biofeedback may be conducted in both inpatient and outpatient settings depending on the use of portable biofeedback devices (e.g. finger thermometers).

Coded E&M **99499** and CPT **90875** or **90876** depending on duration and includes psychotherapy. Coded E&M **99499** and CPT **90901** for biofeedback without psychotherapy. For fecal incontinence biofeedback use CPT **90911**.

Example:

A female family member with migraine headaches is seen for 50 minutes of biofeedback-assisted relaxation. This encounter is coded E&M **99499** and CPT **90876**.

Psycho-educational Groups

These services focus on the biopsychosocial factors that are or could affect treatment of, or severity of, the patient's physical condition. The goal is to modify the psychological, behavioral, emotional, cognitive, and social factors identified as directly affecting the patient's physiological functioning, disease status, health, and general well-being.

Coded E&M **99499** and CPT **96153**-one unit per 15 minutes.

Example:

Examples of psych-educational groups offered include Cardiac Rehabilitation, Diabetes Management, Insomnia Management, Pain Management, Relaxation, Sleep Enhancement, Temperomandibular Disorder Management, and Tobacco Cessation. Tobacco Use Disorders and Sleep Disorders have been determined to be physical health conditions by a multidisciplinary team of clinicians and therefore interventions are appropriately coded using the Health and Behavior codes e.g. 96152, 96153).

Environmental Intervention Commander, First Sergeant, and/or Supervisor

This intervention is usually to discuss job limitations and/or environmental changes that would help the patient in managing their behavioral health condition (e.g. shift changes). Discussion topics may include duty restriction, safety concerns or other patient concerns. It is also common for an intervention to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example:

A 29-year-old active duty member with chronic pain due to degenerative disk disease reports that she was removed from the flight line due to her "back pain" and now sits at a desk all day. She is working on cognitive-behavioral strategies for pain management and would like to return to the flight line. The psychologist meets with the Commander to discuss the benefits of returning to the flight line (e.g. behavioral activation and pacing activities) in this patient's treatment/success at managing the chronic pain. This meeting is coded E&M **99499** and CPT **90882**.

Interpretation and/or Explanation of Results with Family Members, and/or other Responsible Persons or Advising them on How to Assist the Patient

This involvement of others in the therapy/treatment process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

A psychologist meets with a patient with chronic pain and his spouse to discuss ways in which the spouse can help the patient manage the pain more effectively. This meeting is coded E&M **99499** and CPT **90887**.

Preparation of a Report for other Physicians, Agencies, or Insurance Carriers-non-legal Purposes

Reports may be requested by patients for outside agencies, insurance carriers and/or other health care professionals for non-legal purposes. These may include summary of care statements and/or statements of medical conditions.

Coded E&M **99499** and CPT **90889**.

Example:

A 33-year-old female family member has received treatment for chronic pain in the Mental Health Clinic. She and her husband are PCSing, and she plans to continue her mental health treatment at their new location. She asks for a report summarizing her treatment to date to give to her new provider. The preparation of this report is coded E&M **99499** and CPT **90889**.

Medical Team Conferences

This medical conference includes an interdisciplinary team of health professionals or representatives of community agencies meeting to coordinate activities of patient care (the patient is not present). The conference can last 30-60 minutes.

Coded E&M **99366** (face-to-face, 30 min or more, non-physician), **99367** (no face-to-face, 30 min or more, physician) or **99368** (no face-to-face, 30 min or more, non-physician) with no CPT code.

Example:

A 42-year-old active duty member with chronic migraine headaches has been seen by Neurology and is followed in the outpatient Mental Health Clinic. The patient is frequently scheduling medical appointments in Neurology and Primary Care. He has been prescribed narcotic pain medications for his condition, which he now wishes to discontinue. The psychologist schedules a 60-minute medical team conference to discuss with the Neurologist and Primary Care Physician the patient's diagnosis, treatment to date, and plan for tapering of the medication in conjunction with cognitive-behavioral treatment. In this example, each provider may code this encounter separately but must document in separate notes (in S-O-A-P-P format) the nature of their work during this conference. This conference is coded E&M **99368** for the psychologist.

Evaluation for Surgery

These evaluations are medical consults requesting clinical evaluation to identify any mental health conditions which may contraindicate or complicate a patient's participation in a surgical intervention. The evaluation includes a diagnostic interview, a comprehensive medical record review, and may include psychological testing. A consultation response is sent to the requesting provider.

Coded E&M **99499** and CPT **90801** (diagnostic interview), and can include the additional CPT code **96101**-psychological testing as appropriate. Consultation E&M codes could be used for these encounters, but when a mental health provider conducts a complete diagnostic interview, the encounter is more appropriately captured with the psychiatric CPT code **90801**.

Example:

A 45-year-old female family member with a long history of obesity undergoes a psychiatric evaluation prior to Gastric Bypass surgery as a prerequisite for the surgery to identify any mental disorders which may be contraindications or complicate a patient's participation in the surgery. This includes a comprehensive review of the patient's three volume medical record (approximately 60 minutes) and a comprehensive report to the requesting provider (approximately 60 minutes). No psychological testing is completed. This evaluation is coded E&M **99499** and CPT **90801-22**. The modifier **-22** was used to represent the additional time spent performing a detailed and comprehensive review of the patient's medical records and preparing a comprehensive consultation response to the requesting provider.

Inpatient/Ward Consultations-Initial Assessment

This assessment refers to requests from medical providers regarding evaluation of specific mental health needs and/or assistance in diagnosis and treatment of mental health needs. This may involve review of the outpatient and inpatient record and diagnostic interview, and may also include psychological testing. This may also involve phone communication with the requesting provider.

Coded E&M **99251-99255**, consultation codes, or E&M **99499** and the CPT **90801** or **90802**, whichever is more appropriate.

Example:

A consultation is requested to assist a patient on the ward in swallowing pills. The psychologist goes to the ward and gathers a problem-focused history, a problem-focused exam with straightforward medical decision making and spends 10 minutes teaching a brief relaxation exercise while the patient successfully attempts pill swallowing. This encounter is coded E&M **99251.**

Inpatient/Ward Consultations Follow-up

This follow-up can be similar to an outpatient treatment appointment, and may include insight oriented, behavior modifying and/or supportive counseling. An assessment of risk status and a mental status examination is performed. An evaluation of medication compliance and side effects, review of medications, and effectiveness of medication may also be performed. Education, discussion about stressors, identification of cognitive distortions, relaxation strategies, and/or support may also be performed.

Coded E&M **99499** and the CPT depends on the duration of the visit and whether evaluation and management services were also provided as follows: **90816** (20-30 min), **90817** (20 to 30 min with E&M services), **90818** (45 to 50 min), **90819** (45 to 50 min with E&M services), **90821** (75 to 80 minutes), **90822** (75 to 80 min with E&M services). Typically when working with children or if more interactive services are included (e.g. interpreter is used), the consultation is be coded E&M **99499** and CPT **90823** (20 to 30 min), **90824** (20 to 30 min with E&M services), **90826** (45 to 50 min), **90827** (45 to 50 min with E&M services), **90828** (75 to 80 min), and **90829** (75 to 80 min with E&M services).

Example:

A second 20-minute follow-up on inpatient for a patient with pancreatitis who was taught an autogenic relaxation technique the previous day. This encounter is coded E&M **99499** and CPT **90816**.

BEHAVIORAL HEALTH OPTIMIZATION PROGRAM (BHOP) –BHC

This section describes the types of encounters for Behavioral Health Consultants - BHCs. Only mental health providers who have received AF-recognized BHC training can provide these services within the MTF. These services are different in nature than specialty mental health with more specific and problem-focused assessments and consultative support and co-management activities. This service is not simply specialty mental health care provided in primary care; but rather, problem-focused and limited in scope, and follow-up is time-limited (i.e. usually less than 3 visits). There is a focus on the biopsychosocial aspects of health and illness and focused work with individuals with physical health concerns and disease states (e.g. chronic pain, diabetes).

A BHC in primary care is a member of the primary care clinic's healthcare team who assists the PCM in managing the overall health of their enrolled population. The goals are to help improve recognition, treatment, and management of psychosocial/mental problems and conditions in the enrolled population. The PCM remains the primary provider for the patient and is assisted in managing the mental health of the patient by the mental health provider.

The role of the mental health provider in primary care is limited scope of care. Responsibilities of mental health providers in primary care include:

- Targeted assessment and evaluation, including diagnostic impressions and functional status focused on the presenting problem
- Timely and succinct feedback to PCMs regarding findings and recommendations
- Concise documentation of care and recommendations in the patient's medical record
- Determining the appropriateness of the patient receiving services in primary care (Triaging) and referring to specialty mental health care when appropriate (e.g. Life Skills Support Center).
- Formulation of mental health interventions appropriate to the primary care setting, and assisting with implementation of treatment plans
- Providing brief follow-up, including relapse-prevention education
- Developing, teaching, and/or providing oversight for classes that promote education and skill-building to enhance psychological and physical health
- Providing targeted follow-up services for a sub-set of patients who require on-going monitoring and follow-up (e.g., "high-utilizers")
- Sharing knowledge with other team members and patients, both formally (in-services, consult responses) and informally (hallway conversations)

E&M and CPT codes are also listed for each service. Clinicians must use ICD-9-CM codes for data entry purposes. Unique diagnostic issues are highlighted where appropriate.

BHOP workload will be captured using B**W depending on the Primary Care clinic in which the clinical services are performed. These may include Family Practice (BGAW), Primary Care (BGAW), Women's Health (BCBW), Flight Medicine (BJAW), Internal Medicine (BAAW), and Pediatrics (BDAW). It is important that mental health providers accurately document the time they spend working outside of the BF** MEPRS (e.g. outside of BFDA) on their MEPRS timesheets. Therefore, if a mental health provider spends eight hours working in BHAW he/she should be sure to document that on his/her timesheet.

In Primary Care it is not uncommon for the BHC to see the spouse along with the patient. The BHC should document that the spouse was seen, but only code the encounter for the patient. This is similar to a parent who is seen with their child in Primary Care.

Behavioral Health Consultation-Initial Visit

This initial visit is brief, general; oriented to a consultation from a health care provider or PCM. The visit length (approximately 15-30 minutes) matches the pace of primary care. This may involve conjoint "exam room" visits with the PCM. The mental health provider in primary care may focus primarily on psychosocial conditions or mental sequelae of medical conditions. This visit may also include determining the appropriate level of mental health care needed (i.e., is a referral to LSSC appropriate). Assessment of risk status is performed as appropriate (e.g. suicide risk in a patient taking antidepressants).

Code E&M **99241-99245** when services are requested by the PCM. This may include providing some therapeutic services.

Example:

A PCM requests an initial visit for a 45-year-old female family member with panic-like symptoms. The patient is seen for a problem-focused assessment and targeted consultative support for 30 minutes. This encounter includes an expanded problem focused history and exam and straightforward medical decision making. This scenario is coded E&M **99242**.

E&M 99242 requires the following:

E&M 99242 is an office consultation for a new or established patient, which requires these three key components:

- An expanded problem focused history
- An expanded problem focused examination
- Straightforward medical decision making

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Providers typically spend 30 minutes face-to-face with the patient and/or family.

Behavioral Health Consultation-Follow-up visit

This follow-up visit is typically a secondary visit to support a behavior-change plan or treatment started by a PCM based on earlier assessment and consultative support and co-management activities; often in tandem with a planned PCM visit. This visit can include the following:

Compliance enhancement*:* A visit to help the patient comply with an intervention initiated by the PCM; focus on education, addressing negative beliefs, or strategies for coping with medication side effects.

NOTE: Highly effective in helping PCMs improve their treatment for depression in the primary care clinic. The mental health provider in primary care can set up a process to routinely see patients who are prescribed anti-depressant medications. These visits ca be used to address common myths and misunderstandings and to schedule a follow-up appointment to re-assess compliance and medication response.

Relapse prevention*:* A visit to maintain stable functioning in a patient who has responded to previous treatment; often spaced at long intervals.

Behavioral medicine*:* A visit to assist in managing a chronic medical condition, or to tolerate invasive or uncomfortable medical procedures; focus may be on lifestyle or health-risk factors among patients at risk (i.e., tobacco cessation, weight loss); may involve managing issues related to progressive illness, such as end-stage chronic obstructive pulmonary disease, etc.

For subsequent care for the same diagnosis use the established E&M codes **99212-99215**.

Example:

A 24-year-old active duty member is seen for a 30-minute face-to-face second visit to reinforce stress management strategies taught to her on the first visit (e.g. relaxation and goal setting for increased exercise). This visit is coded E&M **99499** and CPT **99214**.

E&M **99214** requires the following:
Office or other outpatient visit for the evaluation and management of a new patient, which requires **at least two of these three** key components:

- A detailed history
- A detailed examination
- Medical decision making of moderate complexity

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 25 minutes face-to-face with the patient and/or family.

The 30 minutes spent with the patient including the counseling provided would meet the definition of this code.

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes.

Biofeedback

Biofeedback requires specialized training and involves both assessment and treatment using biofeedback equipment. It may or may not include psychotherapy. Biofeedback may be conducted in both inpatient and outpatient settings.

In this setting, biofeedback interventions are brief in nature and are coded E&M **99499** and CPT **90901** without behavior modification strategies (e.g. relaxation), or CPT **90875** with behavior modification strategies.

Example:

A 47-year-old active duty pilot is referred for consultation for non-pharmacological strategies for managing hypertension. Relaxation is identified as a skill and a 30-minute biofeedback-assisted relaxation session is conducted. This scenario is coded E&M **99499** and CPT **90875**.

Psycho-educational Groups

This brief, group-based intervention replaces or supplements individual treatment to promote education and building skills. Often, a psychoeducational group can and should be the primary psychological intervention, as many mental health needs can be efficiently addressed in this setting. The focus is on biopsychosocial factors that are or could affect treatment of, or severity of, the patient's physical condition. The goal is to modify the psychological, mental, emotional, cognitive, and social factors that are identified as directly affecting the patient's physiological functioning, disease status, health, and general well-being. These groups are similar to the psycho-educational groups provided on a Clinical Health Psychology service and examples include Diabetes Management, Pain Management, Relaxation, and Sleep Enhancement.

Coded E&M **99499** and CPT **96153**-one unit per 15 minutes.

Example:

A six session 60-minute cognitive-mental chronic pain management group is provided for patients. Each visit is coded E&M **99499** and CPT **96153-4** units.

Group Medical Appointments

Group medical appointments (often referred to as Drop-In Group Medical Appointments) involve an individual encounter with a patient in a multiple patient format (group setting). The patient's individual needs are addressed in a group setting with the availability of a secluded individual appointment if necessary. The medical diagnosis of group members is diverse and can include diabetes, chronic pain, and hypertension to name a few. The focus is on biopsychosocial factors that are or could affect treatment of, or severity of, the patient's physical condition. The goal is to modify the psychological, mental, emotional, cognitive, and social factors that are identified directly affecting the patient's physiological functioning, disease status, health, and general well-being.

Coded E&M **99499** and CPT **96153**-one unit per 15 minutes.

Example:

10 patients are seen for a 90-minute group medical appointment by both a PCM and a mental health provider. The patients have some or all of the following diagnoses: diabetes, chronic pain, hypertension, and dyslipidemia. Each person's needs are addressed in the group. This session has a common theme of goal setting and sticking

with lifestyle changes. The psychologist then talks for 30 minutes on the aspects of goal setting (e.g. setting reasonable goals and relapse prevention strategies). This scenario is coded E&M **99499** and CPT **96153-6** units.

In Group Medical appointments and other shared medical appointments both the mental health provider and physical medicine provider document their encounter and code separately for each patient. In many cases for the mental health provider this may involve walking-in the patients into AHLTA to do so.

Environmental Intervention Commander, First Sergeant, and/or Supervisor

This is usually to discuss job limitations and/or environmental changes that could help the patient in managing their mental health condition (e.g. shift changes). Topics discussed may include duty restriction, a safety concern, or other patient concern. It is also common for this intervention to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example:

A 29-year-old active duty member with insomnia was profiled from driving his truck due to significant sleep difficulties and subsequent impairment in daytime functioning. The provider meets with the Commander to discuss recommended options for facilitating the patient's response to cognitive-mental treatment of insomnia. This meeting is coded E&M **99499** and CPT **90882**.

Interpretation and/or Explanation of Results with Family Members, and/or other Responsible Persons or Advising them on How to Assist the Patient

This involvement of others in the therapy/treatment process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

A spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient). This encounter is coded E&M **99499** and CPT **90887**.

Medical Team Conferences

These medical conferences include an interdisciplinary team of health professionals or representatives of community agencies meeting to coordinate activities of patient care (patient not present). These conferences can last 30-60 minutes.

Coded E&M **99366** (face-to-face, 30 min or more, non-physician), **99367** (no face-to-face, 30 min or more, physician) or **99368** (no face-to-face, 30 min or more, non-physician) with no CPT code.

Example:
A 59-year-old female with Type II Diabetes appears non-adherent to recommendations to make lifestyle changes and appears focused only on making medication changes. The PCM asks to have a meeting with the mental health provider and the diabetes nurse educator to discuss treatment strategies to enhance adherence. The mental health provider facilitates the 60-minute meeting and coordinates follow-up with the patient after the meeting to implement the treatment strategies. In this example, each provider codes this encounter separately, but must document in separate notes (in S-O-A-P-P format) the nature of their work during this medical team conference. This encounter is coded E&M **99367** for the PCM.

ALCOHOL AND DRUG ABUSE PREVENTION AND TREATMENT (ADAPT)

This section describes clinical mental health services provided in ADAPT. E&M and CPT codes are also listed. Clinicians must use ICD-9-CM codes for data entry purposes.

NOTE: The H-Codes will no longer be required. This handbook supersedes the MHS Professional Services and Specialty Coding Guidelines.

All provider extenders, including both 4C mental health technicians and 4C CADACs, will be entered into AHLTA as paraprofessionals and will code the clinical encounters they perform. In the past, there has been confusion regarding CADACs and mental health technicians who are listed as assigned to a PEC 88723 slot on the UMD. These individuals enter their work in AHLTA in the same manner as the other CADACs and mental health technicians who are not assigned to PEC 88723 slots on the UMD. For all CADACs and mental health technicians, the clinical encounter is reflected as workload non-count. *(See Introduction for additional discussion of this issue)*.

Diagnostic Interview with the Substance Use Assessment Tool (SUAT)

The diagnostic interview includes a comprehensive psychosocial assessment. The purpose of the interview is to develop a good case formulation to make an appropriate diagnosis, and begin treatment plan formulation. Providers assess the presenting complaint, the history of present illness, family and social history and a review of habits (e.g. substance use, exercise). A mental status exam is performed and neurovegetative symptoms are assessed. Co-morbid medical conditions, allergies, and current medications, as well as past medical history are documented. Collateral information from family members or other responsible persons (e.g. First Sergeant) may also be obtained. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. This encounter typically takes 60-120 minutes.

Coded with E&M **99499** and CPT **90801 and 96103.**

The SUAT is a computerized assessment which includes patient and provider entered information. The psychometric assessment includes the Alcohol Use Disorders Identification Test (AUDIT), Short Alcohol Dependence Data (SADD), Short Index of Problems, Comprehensive Effects of Alcohol Test, a Readiness to Change Questionnaire, and a Self-Efficacy Item. A full diagnostic Interview with the SUAT will take approximately 90 minutes to complete.

Example:

An 18-year-old is referred for evaluation at ADAPT following an arrest for underage drinking in the dorms. A CADAC meets with the patient and gathers standard history and intake information. The patient spends one hour completing the SUAT. The provider reviews the intake information with the technician. The provider meets with the patient to complete the evaluation. This encounter is coded E&M **99499** and CPT **90801** and **96103**. In this case, the technician is listed as a secondary provider (paraprofessional) in AHLTA.

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes..

Tier 2 (Secondary Prevention) Alcohol Brief Counseling (ABC)

Alcohol Brief Counseling (ABC) is a targeted secondary prevention intervention for individuals who have completed a diagnostic evaluation in the ADAPT clinic and have not been diagnosed with a substance use disorder.

ABC is delivered in one-on-one appointments and each session, if conducted by a privileged provider is coded using the appropriate E&M Preventive Medicine counseling code: 99401 (15 minutes), 99402 (30 minutes), 99403 (45 minutes), 99404 (60 minutes). If the ABC intervention is delivered by a CADAC who has been trained to conduct ABC, each encounter would be coded 99211.

Tier 2 (Secondary Prevention) Psycho-educational Prevention Group related to Alcohol Related Misconduct or life event

This group is secondary prevention for patients without a diagnosis (V71.09 per ADAPT evaluation), but who are at-risk based on recent alcohol related misconduct or other substance related behaviors or history.

Specific prevention counseling and/or risk factor reduction strategies are used with several patients in a group setting. Biopsychosocial factors related to problematic alcohol use are discussed. Interventions may be focused on skill building and strategies for successful health behavior change. Group discussion may include some of the following areas: motivation for change, skills development, setting reasonable and sustainable goals. Group participants are assisted in developing short and long-term risk reduction goals. Skills taught may include maintaining behavior change and developing a relapse prevention plan. Duration will vary. This activity has historically been referred to as the Substance Abuse Awareness Seminar (SAAS).

Coded E&M **99412**, Preventive Medicine Counseling Group. (Individuals already diagnosed with substance abuse or dependence are not appropriate for Tier 2 as it is a secondary prevention activity for an at-risk population.)

Example:

A 20-year-old active duty Senior Airman is assessed by the ADAPT Program Manager (a credentialed provider) who determines that this is a one-time incident and the patient does not meet criteria for alcohol abuse or dependence. The patient attends the Tier 2 SAAS group prevention and her focus is on reducing exposure to high risk situations for alcohol consumption. This scenario is coded E&M **99412**. In this case the ICD-9-CM is coded **V71.09** primary diagnosis and **V79.1**, Screening Alcoholism, for the diagnostic interview appointment and **V65.42_1**, Substance Abuse counseling, for the SAAS encounter.

Tier 3: Psycho-educational Treatment Group Related to Alcohol Related Misconduct or Life Event

This is treatment for patients with current alcohol abuse and/or alcohol dependence diagnoses.

Specific treatment, counseling and/or risk factor reduction strategies are used with several patients in a group setting. The biopsychosocial factors specifically related to alcohol abuse or dependence are discussed. Interventions may focus on skill building and strategies for successful health behavior change. The group discussion may include such topics as interpersonal relationships, examining thoughts, attitudes, emotions related to drinking, examining motivation for change, skill development and setting reasonable and sustainable goals. Group participants are assisted in developing short and long-term abstinence and risk reduction goals. Skills taught may include maintaining behavior change and developing a relapse prevention plan. Duration will vary. The critical components of the group treatment must be discussed with each group member. This activity has historically been referred to as the SAAS.

Coded E&M **99499** and CPT **90853**.

Example:

A 37-year-old is assessed via an ADAPT evaluation who determines that the patient meets the criteria for alcohol abuse after he received his 2nd Driving Under the Influence (DUI). A treatment plan is developed and part of the plan includes the Tier 3 module. Attendance at SAAS class is coded E&M **99499** and CPT **90853**.

Treatment Team Meeting (TTM)

The TTM is an interdisciplinary meeting directly related to patient care and treatment plan. The TTM includes the patient when appropriate as well as the ADAPT Program Manager, patient's commander and/or First Sergeant, and the patient's immediate supervisor. The primary objective of the Treatment Team is to guide the clinical course of treatment of the patient after examining all the facts. The ADAPT Program Manager chairs the TTM and determines the clinical course of treatment for patients in the ADAPT Program. Generally, the TTM lasts 30 minutes, but in unusual circumstances may last 60 minutes or more.

Coded E&M **99499** and CPT **90887**.

Example A:

A TTM is convened to discuss the treatment plan with the patient's commander and the Squadron's First Sergeant. The ADAPT Program Manager reviews salient points from the evaluation and the Commander and 1st Sgt discuss the pros and cons of the pateint's work performance. The ADAPT Program Manager recommends SAAS Tier 2 and bi-weekly sessions with the ADAPT Program Manager. The commander agrees and communicates her support for the treatment plan. The patient is not present. This meeting is coded E&M **99499** and CPT **90887**.

Example B:

Same as previous example, but patient came for additional 15 minutes of meeting. The ADAPT Program Manager, 1st Sgt and commander discuss with the patient the positive behaviors as well as concerns they have about his longer term prognosis. Patient acknowledges past poor choices and discusses his plan for avoiding further incidents. 1st Sgt offered assistance with portion of patient's plan. This scenario is coded E&M **99499** and CPT **90887.**

Individual Treatment/Aftercare

Individual treatment can include insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved psychosocial functioning. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Assessment of risk status and a mental status examination is performed. Brief psychological screening

instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2). The treatment appointment generally ranges from 30 minutes to two hours.

Coded depending on the length of the appointment E&M **99499** and CPT **90804**, **90806**, or **90808**.

Example A:

A 50-minute individual psychotherapy session by provider was conducted with a 21-year-old active duty member who was recently arrested and charged with DUI. Discussion included harm reduction strategies and responsible drinking. This session is coded E&M **99499** and CPT **90806**.

Example B:

Same as above, but patient was seen by the CADAC for an individual follow-up. After the session, the CADAC reviews the content of the session with the provider who met with the patient briefly to highlight main points of risk reduction strategies and responsible drinking and confirm that the patient's neurovegetative symptoms were within normal limits. This scenario is coded E&M **99211**.

Group Treatment/Aftercare

— *Includes psycho-educational, and process and/or support groups.*

Psychotherapy may be conducted with several patients in a group setting. The personal dynamics of an individual may be discussed by the group and the dynamics of the group may be explored at the same time. Interpersonal interactions, support, and emotional catharsis are other examples of the processes explored in group settings. Interventions may be focused on skill-building and subsequent mental change. The groups range in duration from 45-120 minutes.

Coded E/M **99499** and CPT **90853**.

Example A:

The patient attends substance abuse group (process and support) each week. The group is run by the provider. The group focuses on each group member reviewing their alcohol use history, reasons for their alcohol use and ways to reduce risk and avoid alcohol-related incidents in the future. This session is coded E/M **99499** and CPT **90853**.

Example B:

Same as previous example, but the majority of group is managed by a CADAC and the provider comes into group for approximately 10 minutes and observes, makes comments and participates in the therapeutic discussions. The CADAC writes the group note in AHLTA and lists self as provider-extender ("paraprofessional"), the provider reviews and signs the note. This session is coded E&M **99211.**

Family Psychotherapy

Family members may also be involved with a patient's care. For example, family members may be taught skills to improve communication in the family. Family psychotherapy can be done in an individual or group setting.

Coded E&M **99499** and CPT **90846** for family psychotherapy without the patient present, E&M **99499** and CPT **90847** for family psychotherapy with the patient present, and E&M **99499** and CPT **90849** for multiple-family group psychotherapy.

Example:

An active duty member receiving clinical services in the ADAPT program and his spouse are seen. Provider spends 15-20 minutes with the couple helping them develop a plan to reduce arguments. The provider and patient then meet for 30 minutes to review his alcohol use, risk reduction plan, and patient's attempts to resolve a work-related issue. This scenario is coded E&M **99499** and CPT **90847** with documentation in the patient's record.

Environmental Intervention: Commander, First Sergeant, and/or Supervisor

This intervention is usually to discuss job limitations and/or environmental changes that would help the patient in managing their mental health condition (e.g. shift changes). Discussion topics may include duty restriction, safety concerns, or other patient concerns. It is also common for this intervention to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example A:

The provider meets with the patient, his commander, and his supervisor in the patient's workplace to discuss the current impact of his rotating shift work on his sleep, and how this is contributing to his increasing depression and alcohol use. The provider requests

that command consider moving the patient on non-rotating day shift for the duration of current treatment phase. This meeting is coded E&M **99499** and CPT **90882**.

Example B:

A few days before, the patient came to an individual follow-up session very frustrated and upset about a particular supervisor because of how they conduct business and the member's perception regarding the supervisor's treatment of her. The provider and the patient mapped out a plan for better coping: the patient agreed to better monitor her thinking and interpretation of interactions, and the provider agreed to call the 1st Sgt and inform him of the situation and recommend either review of situation by outsider or moving patient to another shift. On a separate day, the provider meets with the 1st Sgt, discusses above, 1st Sgt voices his view that supervisor is new, does need mentoring, but wants to discuss directly with the patient the specifics of her concerns. This meeting is coded E&M **99499** and **90882**.

Interpretation and/or Explanation of Results with Family Members, and/or other Responsible Persons or Advising them on How to Assist the Patient

The involvement of others in the therapy/treatment process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

A TTM is convened to discuss the results of the evaluation and the treatment plan with the Commander and the squadron's First Sergeant. Based on the evaluation and diagnosis, the ADAPT Program Manager recommends that the patient attend SAAS Tier 2 and bi-weekly sessions with the ADAPT Program Manager. The commander agrees to support the member in attending treatment sessions and also notes concerns about the member's several other minor infractions, e.g., late for work, not following through, etc. The ADAPT Program Manager discusses some options for the commander to consider in managing such disciplinary issues. This meeting is coded E&M **99499** and CPT **90887**.

Preparation of a Report for Other Physicians, Agencies, or Insurance Carriers-non-legal Purposes

Reports may be requested by patients for outside agencies, insurance carriers and/or other health care professionals for non-legal purposes. These reports may include summary of care statements and/or statements of medical conditions.

Coded E&M **99499** and CPT **90889**.

Example:

At the patient's documented request, the mental health provider prepares a summary report for the patient's off duty employer. The report includes the patient's diagnosis, basics of the treatment plan, and progress to date. Preparation of this report is coded E&M **99499** and CPT **90889**.

Pharmacologic Management without Psychotherapy-Services Provided by Medical Director of ADAPT or other Prescribing Provider

A prescribing provider may review labs and evaluate patients for medications. Compliance with and side effects of existing psychotropic prescription(s) may also be assessed. Dose is adjusted as needed, or agents are changed after discussing risks, benefits, and indications of the medication. Labs are ordered as indicated (about 15-20 minutes).

Coded E&M **99499** and CPT **90862**.

Example:

The patient was seen by a psychiatrist to review abnormal findings on the patient's labs and to discuss the risks and benefits of a trial of an Selective Serotonin Reuptake Inhibitor (SSRI) to help manage the patient's depression, which complicates their responsible drinking plan as patient tends to drink when depressed. This scenario is coded E&M **99499** and CPT **90862**.

FAMILY ADVOCACY PROGRAM (FAP)

This section describes the types of clinical services performed within the FAP. Clinicians must use the ICD-9-CM codes for data entry purposes. Unique diagnostic issues are highlighted where appropriate.

The Defense Health Program (DHP) funded social workers and psychologists who provide clinical care within the FAP capture their workload in their respective MEPR.

Diagnostic Interview

The diagnostic interview includes a comprehensive psychosocial assessment. The purpose of the interview is to develop a good case formulation to make an appropriate diagnosis, and begin treatment planning. Providers assess the presenting complaint, the history of present illness, family and social history, and a review of habits (e.g. substance use, exercise). A mental status exam is performed and neurovegetative symptoms are assessed. Co-morbid medical conditions, allergies, and current medications, as well as past medical history are documented. Collateral information from family members or other responsible persons (e.g. First Sergeant) may also be obtained. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Typically, this is a 90-120 minute activity.

Coded with E&M **99499** and CPT **90801** (adults) or **90802** (typically used with children due to interactive nature).

Example:

Diagnostic interview with alleged perpetrator of family maltreatment, diagnostic interview with victim of spousal abuse.

Telephone Contact

Refer to the MHS Coding Guidance: Professional Services and Special Coding Guidelines for the use of telephone contact codes.

Individual Psychotherapy

Individual treatment can include insight oriented, behavior modifying and/or supportive counseling. A working alliance is established with the patient and a treatment plan is identified using active listening, empathy, reflection, constructive feedback and other techniques to help lead the patient to decreased subjective distress, and/or improved

psychosocial functioning. A multi-axial and differential diagnosis is performed, a treatment plan is developed, and follow-up plans (i.e. disposition) are identified. Assessment of risk status and a mental status examination is performed. Brief psychological screening instruments may also be used to monitor treatment progress (e.g. BDI-II, OQ-45.2).

Coded depending on the length of the appointment E&M **99499** and CPT **90804**, **90806**, or **90808**.

Example:

Active duty member scheduled appointment with the Family Advocacy Treatment Manager (FATM) for 50 minutes of individual psychotherapy to address active listening techniques. This session is coded E&M **99499** and CPT **90806**.

Family Psychotherapy

Family members may also be involved with a patient's care. For example, family members may be taught skills to improve communication in the family. Family psychotherapy can be done in an individual or group setting.

Coded E&M **99499** and CPT **90846** for family psychotherapy without the patient present, E&M **99499** and CPT **90847** for family psychotherapy with the patient present, and E&M **99499** and CPT **90849** for multiple-family group psychotherapy.

Example:

A family therapy session is held to address speaker listener technique. The family practices skills in role playing exercises. This session is coded E&M **99499** and CPT **90847.**

Marital Therapy

Initial diagnostic interviews conducted for both partners to identify goals for treatment and multi-axial diagnosis. Marital therapy may include addressing couple conflict and providing assistance with communication and conflict resolution skills. Diagnostic/screening psychological instruments may also be used during the assessment and to track treatment progress.

Coded E&M **99499** and **90801** for both patients for the first appointment and E&M **99499** and CPT **90847** for subsequent treatment sessions.

Example:

An active duty married couple participates in a 60-minute marital therapy session. They address couple conflict around parenting styles. This session is coded E&M **99499** and CPT **90847** for one spouse; other spouse is documented separately and coded E&M **99499**.

Group Psychotherapy

Group Psychotherapy includes psychoeducational, and process and/or support groups. Psychotherapy may be conducted with several patients in a group setting. The personal dynamics of an individual may be discussed by the group and the dynamics of the group may be explored at the same time. Interpersonal interactions, support, and emotional catharsis are other examples of the processes explored in group settings. Interventions may be focused on skill-building and subsequent mental change. The groups range in duration from 60-120 minutes.

Coded E&M **99499** and CPT **90853**.

Example:

A six session 90-minute parenting class is provided for parents who are in need of consistent active parenting techniques. Parents are provided workbooks and must review lesson plans and complete all required assignments. Each session is coded E&M **99499** and CPT **90853**.

Face-to-Face Meeting with Commander, First Sergeant, and/or Supervisor-Environmental Intervention

This meeting is usually to discuss job limitations and/or environmental changes that would help the patient in managing their mental health condition (e.g. shift changes). This intervention may include a discussion of duty restriction, a safety concern, or other patient concern. It is common for this meeting to occur following an inpatient hospitalization.

Coded E&M **99499** and CPT **90882**.

Example:

Discuss with supervisor safety plan involving the active duty member. The active duty member is a victim of severe physical abuse by her spouse. This meeting is coded E&M **99499** and CPT **90882**.

Face-to-Face meeting with Family members, Commander, First Sergeant, and/or Supervisor-Interpretation and/or Explanation of Results or Advising them on how to Assist the Patient

The involvement of others in the therapy/treatment process is usually to explain results or advise them on how to assist the patient. For example, a spouse may be taught strategies to assist the patient in progressing on identified goals (e.g. exercising with the patient).

Coded E&M **99499** and CPT **90887**.

Example:

A 25-year-old active duty member has difficulty maintaining control over his anger. The commander comes in to discuss recommended options for facilitating the active duty member's response to anger management treatment. This meeting is coded E&M **99499** and CPT **90887**.

Preparation of a Report for Other Physicians, Agencies, or Insurance Carriers-non-legal Purposes

Reports may be requested by patients for outside agencies, insurance carriers and/or other health care professionals for non-legal purposes. These may include summary of care statements and/or statements of medical conditions.

Coded E&M **99499** and CPT **90889**.

Example:

Report prepared for Department of Children and Family Services addressing FAP findings involving a family. Recommendations were documented to ensure that both agencies address family's needs. The preparation of this report is coded E&M **99499** and CPT **90889**.

Medical Team Conferences

Medical Team Conferences include an interdisciplinary team of health professionals or representatives of community agencies meeting to coordinate activities of patient care and can range from 30-60 minutes.

Coded E&M **99366** (face-to-face, 30 min or more, non-physician), **99367** (no face-to-face, 30 min or more, physician) or **99368** (no face-to-face, 30 min or more, non-physician) with no CPT code.

Example:

The Child Sexual Maltreatment Response Team (CSMRT) meets for two hours to address allegations of child sexual abuse with the active duty father as the alleged perpetrator. Safety concerns are addressed and jurisdiction. The Office of Special Investigations (OSI) will follow up with investigation and requests that FAP refrain from interviewing the family at this time. FATM will be included to observe Forensic Child Sexual Abuse interview. In this example, each provider may code this encounter separately but must document in separate notes (in S-O-A-P-P format) the nature of their work during this medical team conference. This meeting is coded E&M **99366** for the non-physician providers.

APPENDIX A – PSYCHIATRIC EXAMINATION WORKSHEET

Patient History

Chief Complaint — **New Patient** — **Established Patient**

To qualify for a given type of history, all three elements (HPI, ROS, PFSH) in the table must be met.

HPI	ROS	PFSH	Type of History
Location, Quality, Severity, Duration, Timing, Context, Mod Factor, Assoc S&S	Allergic/Imm, Constitutional, Hem/Lymph, ENMT, Integument, Eyes, GI, GU, CV, Endocrine, Musc/Skel, Neurological, Psychiatric, Respiratory	Past History, Family History, Social History	*Documentation of history of present illness, review of systems, and past, family and/or social history establishes the type of history.*
Brief HPI = 1-3			Problem Focused
Brief HPI = 1-3	Problem Pertinent ROS = Related System		Expanded Problem Focused
Extended HPI = 4 or >/3 Chr	Extended ROS = 2-9 Systems	Pertinent PFSH = 1	Detailed
Extended HPI = 4 or >/3 Chr	Complete ROS = 10 or > Systems	Complete = 2-3	Comprehensive

Psychiatric Examination

Constitutional

Vital Signs (3)

BP ↑/↓ — Temp
BP → — Height
Pulse RR — Weight
Respiration

General Appearance

Musculoskeletal

Gait & Station Exam
Assess Muscle Strength & Tone

Psychiatric

Description of Speech
Description of Thought Processes
Description of Associations
Description of Abnormal/Psychotic Thoughts
Description of Judgment
Brief MSE:
Orientation Time, Place & Person
Recent & Remote Memory
Attention Span & Concentration
Language
Fund of Knowledge
Mood & Affect

Type of Examination

Perform and Document:

Problem Focused: 1-5 bulleted ( ) elements

Expanded Problem Focused: 6 or > bulleted ( ) elements

Detailed: 9 or > bulleted ( ) elements

Comprehensive: Perform all elements identified by a bullet ( ), document all elements in a box with a border and 1 element in each box with no border

Medical Decision Making

To qualify for a given type of decision making, two of the three elements in the table must be either met or exceeded.

Number of Diagnoses❖/Management Options ♦	Amount/Complexity Data to be Reviewed	Risk of Complications/ Morbidity/Mortality	Type of Medical Decision Making
Minimal ❖One self-limited or minor problem ♦ Rest, gargles, superficial dressings	*Minimal or None* Venipuncture labs, CXR, EKG, UA, Ultrasound	*Minimal*	Straightforward
Limited ❖2 or > self-limited/minor problems, 1 stable chronic illness/acute uncomplicated illness ♦ Over the counter drugs, minor OR (no identified risk), OT/PT, IV fluids without additives	*Limited* Non-Stress tests/pulmonary function, superficial needle biopsy, labs arterial puncture, non-CV imaging	*Low*	Low Complexity
Multiple ❖1 or > chronic illnesses with mild exacerbation, 2 or > stable chronic illnesses, new problem (uncertain prognosis), acute illness with systemic symptoms, acute complicated injury ♦ Minor OR (risk identified), elective major OR, prescription drug mgmt, IV fluids with additives, closed tx of fractures, therapeutic nuclear medicine	*Moderate* Stress studies, endoscopies (no risk), CV imaging (no risk) e.g., arteriogram, angiogram, fluid from body cavity e.g., thoracentesis	*Moderate*	Moderate Complexity
Extensive ❖1 or > chronic illnesses with severe exacerbation, acute/chronic illnesses/injuries with threat to life/bodily function e.g., multiple trauma, acute MI, pulmonary embolus ♦ Elective major OR, ER major surgery, parenteral controlled substances, DNR decision	*Extensive* CV Imaging (risk), EPS, endoscopy (risk)	*High*	High Complexity

☐ Represents boxes with shaded border in HCFA Guidelines.

E/M Code Assignment _____

Psychiatric Examination

System/Body Area	Elements of Examination
Constitutional	• Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2)supine blood pressure, 3)pulse rate and regularity, 4)respiration, 5)temperature, 6)height, 7)weight (may be measured and recorded by ancillary staff • General appearance of patient (e.g. development, nutrition, body habitus, deformities, attention to grooming)
Head and Face Eyes Ears, Nose, Mouth and Throat Neck Respiratory Cardiovascular Chest (breasts) Gastrointestinal (Abdomen) Genitourinary Lymphatic	
Musculoskeletal	• Assessment of muscle strength and tone (e.g. flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements • Examination of gait and station
Extremities Skin Neurological	
Psychiatric	• Description of speech including: volume; articulation; coherence; and spontaneity with notation of abnormalities (e.g., perseveration, paucity of language) • Description of thought processes including: rate of thoughts; content of thoughts (e.g. logical vs. illogical, tangential); abstract reasoning; and

	computation • Description of associations (e.g. loose, tangential, circumstantial, intact) • Description of abnormal or psychotic thoughts including: hallucinations; delusions; preoccupation with violence; homicidal or suicidal ideation; and obsessions • Description of the patient's judgment (e.g. concerning everyday activities and social situations) and insight (e.g. concerning psychiatric condition) Complete mental status examination including: • Orientation to time, place and person • Recent and remote memory • Language (e.g. naming objects, repeating phrases) • Fund of knowledge (e.g. awareness of current events, past history, vocabulary) • Mood and affect (e.g. depression, anxiety, agitation, hypomania, lability)

Content and Documentation Requirements	
Level of Exam	**Perform and Document**
Problem Focused	One to Five elements identified by a bullet.
Expanded Problem Focused	At least six elements identified by a bullet.
Detailed	At least nine elements identified by a bullet.
Comprehensive	Perform all elements identified by a bullet; document every element in the Psychiatric and Constitutional and at least one element in the Musculoskeletal.

These worksheets must be used to determine the appropriate E&M code to use and documentation must reflect the areas addressed and evaluated to support the use of a particular code.

APPENDIX B – CONSULTATION

Office consultation: New or Established Patient

99241 Office consultation for a new or established patient, which requires these three key components:
▪A problem-focused history;
▪A problem-focused examination; and
▪Straightforward medical decision making.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are self limited or minor. Providers typically spend 15 minutes face-to-face with the patient and/or family.

99242 Office consultation for a new or established patient, which requires these three key components:
▪An expanded problem focused history;
▪An expanded problem focused examination;
▪Straightforward medical decision making.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of low severity. Providers typically spend 30 minutes face-to-face with the patient and/or family.

99243 Office consultation for a new or established patient, which requires these three key components:
▪A detailed history;
▪A detailed examination;
▪Medical decision making of low complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate severity. Providers typically spend 40 minutes face-to-face with the patient and/or family.

99244 Office consultation for a new or established patient, which requires these three key components:

▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of moderate complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 60 minutes face-to-face with the patient and/or family.

99245 Office consultation for a new or established patient, which requires these three key components:
▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of high complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 80 minutes face-to-face with the patient and/or family.

Inpatient Consultations: New or Established Patient

99251 Inpatient consultation for a new or established patient, which requires these three key components:
▪A problem-focused history;
▪A problem-focused examination; and
▪Straightforward medical decision making.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are self limited or minor. Providers typically spend 20 minutes at the bedside and on the patient's hospital floor or unit.

99252 Inpatient consultation for a new or established patient, which requires these three key components:
▪An expanded problem focused history;
▪An expanded problem focused examination;
▪Straightforward medical decision making.
Counseling and/or coordination of care with other providers or agencies are

provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of low severity. Providers typically spend 40 minutes at the bedside and on the patient's hospital floor or unit.

99253 Inpatient consultation for a new or established patient, which requires these three key components:
▪A detailed history;
▪A detailed examination;
▪Medical decision making of low complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate severity. Providers typically spend 55 minutes at the bedside and on the patient's hospital floor or unit.

99254 Inpatient consultation for a new or established patient, which requires these three key components:
▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of moderate complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 80 minutes at the bedside and on the patient's hospital floor or unit.

99255 Inpatient consultation for a new or established patient, which requires these three key components:
▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of high complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 110 minutes at the bedside and on the patient's hospital floor or unit.

APPENDIX C – E&M CODES FOR OFFICE OR OTHER OUTPATIENT SERVICES

The following are E& M codes for Office or Other Outpatient Services for a New Patient.

99201 Office or other outpatient visit for the evaluation and management of a new patient, which requires these **three** key components:
- A problem focused history;
- A problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are self limited or minor. Providers typically spend 10 minutes face-to-face with the patient and/or family.

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires these **three** key components:
- An expanded problem focused history;
- An expanded problem focused examination;
- Straightforward medical decision making.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are low to moderate severity. Providers typically spend 20 minutes face-to-face with the patient and/or family.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires these **three** key components:
- A detailed history;
- A detailed examination;
- Medical decision making of low complexity.

Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate severity. Providers typically spend 30 minutes face-to-face with the patient and/or family.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires these **three** key components:
- A comprehensive history;

▪A comprehensive examination;
▪Medical decision making of moderate complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 45 minutes face-to-face with the patient and/or family.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires these **three** key components:
▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of high complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 60 minutes face-to-face with the patient and/or family.

The following are E&M codes for an **Established Patient:**

99211 Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a provider. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services .

99212 Office or other outpatient visit for the evaluation and management of an established patient, which requires **at least two of these three** key components:
▪A problem-focused history;
▪A problem-focused examination;
▪ Straightforward medical decision making.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are self limited or minor. Providers typically spend 10 minutes face-to-face with the patient and/or family.

99213 Office or other outpatient visit for the evaluation and management of a new patient, which requires **at least two of these three** key components:
▪An expanded problem focused history;
▪An expanded problem focused examination;
▪Medical decision making of low complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are low to moderate severity. Providers typically spend 15 minutes face-to-face with the patient and/or family.

99214 Office or other outpatient visit for the evaluation and management of a new patient, which requires **at least two of these three** key components:
▪A detailed history;
▪A detailed examination;
▪Medical decision making of moderate complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 25 minutes face-to-face with the patient and/or family.

99215 Office or other outpatient visit for the evaluation and management of a new patient, which requires **at least two of these three** key components:
▪A comprehensive history;
▪A comprehensive examination;
▪Medical decision making of high complexity.
Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.
Usually, the presenting problem(s) are of moderate to high severity. Providers typically spend 40 minutes face-to-face with the patient and/or family.

APPENDIX D – DOCUMENTATION

Diagnostic interview assessments should include:

- Description of emotional or mental symptoms that demonstrate inappropriate or maladaptive functioning that is significant change in patient's baseline level of functioning.
- Date and time spent in psychotherapy session.
- Referral source (if applicable)
- History of present illness, including length of existence of problems/symptoms/conditions
- Past psychiatric history
- Significant medical history and current medications
- Assessment of Habits (i.e., Alcohol, Tobacco, exercise)
- Social history
- Mental status exam
- Strengths/liabilities
- Multi-axis diagnosis or diagnostic impression list-including problem list
- Treatment plan

Follow-up Appointments

- Presence of a psychiatric illness and/or the demonstration of emotional or mental symptoms sufficient to significantly alter baseline function
- Date and time spent face-to-face with the patient
- Pre- and post- non face-to-face encounter time is not reportable or included in documentation time
- Setting in which psychotherapy session occurred
- Type of therapeutic interventions (e.g., behavior modification, supportive interaction, discussion of reality) which were applied to produce therapeutic change
- Capacity of patient to participate in and benefit from psychotherapy
- Disposition and plan for follow-up
-

Group Treatment:

- Presence of a psychiatric illness and/or the demonstration of emotional or mental symptoms sufficient to alter baseline functioning.

- Content of session, including therapeutic interventions such as behavior modification, supportive interaction and discussion of reality.
- Degree of patient participation and interaction with the group members and leader, the reaction of the patient to the group, the group's reaction to the patient and the changes or lack of changes in patient symptoms and/or behavior as a result of the group session.
- Date and time spent in psychotherapy encounter/session.

Diagnostic Assessment Note

	Clinic Note	Outpatient Record (OPR) Note
	*Date and Pt identifying information (name and FMP/last four) – each page *Type of patient and type of service (e.g. 34-year-old AD married Caucasian male seen for initial assessment) Voluntary or Command Directed Informed consent given Deployment related = Yes or No (if yes, include appropriate deployment-related V-code as primary ICD-CM) Length of service or time (i.e. 45 minutes or 0800-0845) Scope of service – what happened in SOAPP format below for assessment and therapy visits:	
S	Complete psychiatric history, including presenting illness; past history, and family history. A review of habits including substance use, tobacco use, exercise, and caffeine use.	Brief statement of presenting problem or treatment issue (i.e. chronic depression). Additional information important for a medical provider to know (i.e. substance abuse history, medical complaints, etc). Use careful clinical judgment when exceeding these minimum standards. Statement of separate records (e.g. SEPARATE RECORD MAINTAINED IN ____ (e.g. Mental Health Clinic).
	If prescribing provider, medication management, informed consent, (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in P section).	
O	Mental Status and other clinical observations, including assessment of suicidality and homicidality.	
	Results of screening instruments (OQ45, etc)	Not required in OPR
A	DSM-IV-TR Diagnoses (OPR system will use ICD-9-CM terms) -All five axes at initial assessment and termination/transfer of care -Axis I, II and III for sessions between initial assessment and termination/transfer of care Documentation of Suicide and Violence Risk (required at initial and every session for which elevated risk is documented). Documentation of the risk assessment may be in the S/O section of the note.	
P	Initial treatment plan: e.g., focus of treatment, estimated frequency and duration of care, and modality of treatment (e.g. cognitive-behavioral therapy, insight-oriented, supportive, etc). If risk is elevated, interventions targeting risk should be documented.	Follow up plan (when) Type of treatment needed (individual, group, med management)??
	Summary of referrals made or contacts with others (PCM, CC, etc): *If prescribing provider, medication management, informed consent (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in the S section)* Profile Statement including if WWQ for deployment from mental health perspective -e.g. Deploy = Go or No Go -e.g. Profile = S4T until 1Dec05 Special duty considerations/limitations: PRP, Flying Status, Weapon bearing, Security Clearance Statement of High-Interest Clinic Log, if applicable	
P	Prevention activities/advice given.	
	Signature and stamp or printed name of all involved in visit	

Individual Psychotherapy- Follow Up Note

	Clinic Note	Outpatient Record (OPR) Note
	*Date and *Pt identifying information (name and FMP/last four) – each page *Type of patient and type of service (e.g. 34-year-old AD married Caucasian male seen for initial assessment) Deployment related = Yes or No (if yes, include appropriate deployment related V code) Length of service or time (i.e. 45 minutes or 0800-0845) Scope of service – what happened in SOAPP format below for assessment and therapy visits:	
S	Summary of content of session: how they are doing and what you are doing with them. May include the following elements; major themes, current situation and severity, patient interpersonal and/or interverbal exchanges, review of homework, skills used to produce therapeutic changes, patient compliance, reasons for changes in treatment plan or diagnosis, and progress toward goals.	Changes to initial problem or treatment issue (e.g. new problem, changes in mental status, diagnostic changes, or significant change in treatment plan). Additional information important for a medical provider to know (i.e. substance abuse history, medical complaints, etc). Use careful clinical judgment when exceeding these minimum standards. Statement of separate records (e.g. SEPARATE RECORD MAINTAINED IN___ (e.g.Mental Health clinic)).
	If prescribing provider, medication management, informed consent (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in P section).	
O	Mental Status and other clinical observations, including assessment of suicidality and homicidality.	
	Results of screening instruments (OQ45, etc)	Not required in OPR
A	DSM-IV Diagnoses (OPR system will use ICD-9-CM terms) -Document diagnoses and symptoms for which you are providing treatment. May include all five axes if applicable. If termination/transfer of care, all five must be documented. Document Axis I, II, and III for sessions between initial and termination/transfer of care. Documentation of Suicide and Violence Risk (required at every session for which elevated risk is documented). Documentation of the risk assessment may be in the S/O section of the note.	
P	Changes in treatment plan (e.g. frequency of visits), homework (if given) and follow up plan (e.g. when/what you will do next session). If elevated risk, interventions targeting risk documented.	Follow up plan (when) Need type of treatment listed (individual, marital, group)??
	Summary of referrals made or contacts with others (PCM, CC, etc):*If prescribing provider, medication management, informed consent (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in the S section)* Profile Statement including if WWQ for deployment from mental health perspective -e.g. Deploy = Go or No Go -e.g. Profile = S4T until 1Dec05 Special duty considerations/limitations: PRP, Flying Status, Weapon bearing, Security Clearance Statement of High Interest Clinic Log, if applicable	
P	Prevention activities/advice given.	
	Signature and stamp or printed name of all involved in visit	

Group Psychotherapy and/or Psych-educational Group Note

	Clinic Note	Outpatient Record (OPR) Note
	*Date and Patient identifying information (name and FMP/last four) – each page *Type of patient and type of service (e.g. 34-year-old AD married Caucasian male seen for initial assessment) Length of service or time (i.e. 45 minutes or 0800-0845) Scope of service – what happened in SOAPP format below for assessment and therapy visits:	
S	Summary of content of session. May include the following elements; key issues presented, relationship of the group to therapy theme or goal, skills used to produce therapeutic changes, and progress toward goals. Individual notes may include any information regarding the patient's unique issues related to the whole group, such as response to treatment.	<u>Will usually just state that they attended the group</u>, but may include changes to initial problem or treatment issue (e.g. new problem, changes in mental status, diagnostic changes, or significant change in treatment plan).
		Additional information important for a medical provider to know (i.e. substance abuse history, medical complaints, etc). Use careful clinical judgment when exceeding these minimum standards. Statement of separate records (e.g. SEPARATE RECORD MAINTAINED IN ____ (e.g. Mental health clinic)).
	If prescribing provider running a medication group, medication management, informed consent (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in P section).	
O	Mental Status and other clinical observations, including assessment and documentation of suicidality and homicidality.	
	Results of screening instruments (OQ45, etc)	Not required in OPR
A	DSM-IV Diagnoses (OPR system will use ICD-9-CM terms): -Document diagnoses and symptoms for which you are providing treatment. Should be the diagnosis for which they were referred to the group for treatment.	
P	Follow up plan (e.g. when and what you will do next session). If final group session, follow up plan after group (e.g. referred back to referring provider for continuation of individual treatment).	Follow up plan (e.g. when, referred back to referred provider, or PRN).
	Summary of referrals made or contacts with others (PCM, CC, etc) *If prescribing provider running a medication group, medication management, informed consent (risks, benefits, side effects, and alternative treatments discussed) and tests/labs reviewed/ordered (may also be documented in the S section)*	
	Profile Statement including if WWQ for deployment from mental health perspective or statement of deferral. -e.g. Diagnosis, Profile, Deployability, and high-interest clinic log deferred to referring provider. Assume S1 WWQ for deployment unless otherwise indicated in chart.	
P	Prevention activities/advice given.	
	Signature and stamp or printed name of all involved in visit	

Telephone Contact for the Mental Health Record and Outpatient Record

*Date and time

*Patient identifying information (name and FMP/last four) – each page

Length of service or time (i.e. 45 minutes or 0800-0845)

S Summary of content of communication (e.g. Chief Complaint and additional information received as appropriate to document in the OPR on mental health patients).

If prescribing provider, medication management, medications (OTC or prescription) being taken, prescriptions ordered (date and time), informed consent regarding medication changes (risks, benefits, side effects, and alternative treatments discussed), and tests/labs reviewed/ordered. Some items may be documented in the P section of note.

Use careful clinical judgment when exceeding these minimum standards. Statement of separate records (e.g. SEPARATE RECORD MAINTAINED IN ____).

O Mental Status and other clinical observations, including assessment and documentation of suicidality and homicidality as appropriate.

A DSM-IV-TR Diagnoses (Outpatient record system will use ICD-9-CM terms)
-Document diagnoses and symptoms for which you are providing treatment.

P Follow up plan (e.g. when should they return for care).

P Prevention activities/advice given.

Signature and stamp or printed name of all involved in visit

APPENDIX E – MEDICAL EXPENSE PERFORMANCE REPORTING SYSTEM (MEPRS)

Just as standardized coding of clinical encounters helps the AF Medical Service better account for workload and productivity, common MEPRS coding practices will help the AF Medical Service account for the costs, manpower, and work associated with various medical cost centers. Accurate MEPRS coding should lead to a closer match between the manning and budget allocated to a clinic and its actual requirements.

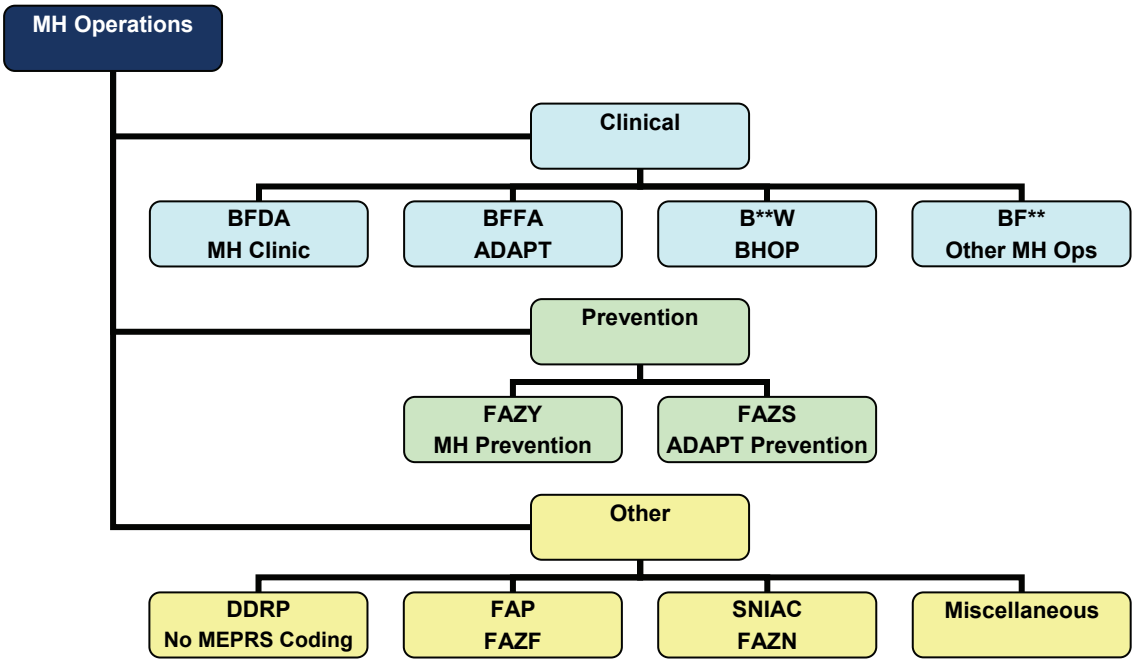
General Guidelines:

1. Outpatient Mental Health Clinics: Most time spent in outpatient mental health settings will be coded using one of the BF** codes (i.e., BFAA, BFBA, BFCA, BFDA, BFEA, and BFFA). This code includes almost all activities that occur within the mental health clinic, including direct clinical care, command consultation regarding specific patients, crisis response regarding specific patients (e.g., HRVRT, CSMRT), operational evaluations (e.g., aspects of security clearance evaluation that are clinical), clinical administrative functions (e.g., writing notes, profiles, reports), and clinic management activities (e.g., schedule planning, template management, staff meetings). Wherever possible, MTFs should realign their UMD and MEPRS coding so that all mental health outpatient operations fall under BFDA, except where truly distinct psychiatry (BFAA), psychology (BFBA), child (BFCA), social work (BFEA), or substance abuse (BFFA) clinics exist. At most small to medium-sized MTFs, BFDA should be sufficient. Additional BF** codes can be added as clinics grow in size and function. As a general rule, wherever appropriate, direct face-to-face encounters with patients should be coded as clinical visits and the time accounted for under a BF** code.
2. Behavioral Health Optimization Program: Time spent in primary care providing BHOP services will be coded as B**W, depending on the clinic in which the BHOP service was provided.
3. Community Prevention Services: Time spent on community prevention services will be coded as FAZY (mental health promotion) or FAZS (substance abuse prevention).
4. Special Needs Identification and Assignment Coordination (SNIAC) Process: Administrative time spent on SNIAC will be coded as FAZN, but face-to-face contacts with customers should be coded as clinical contacts under BF** wherever appropriate.
5. Family Advocacy Program (FAP): Administrative time spent in FAP by military personnel or DHP-funded civilian personnel will be coded as FAZF. Clinical time spent in FAP by military personnel or DHP-funded civilian personnel will be coded as BF**. Most civilian personnel assigned full time to FAP will code all their time as FAZF.
6. Alcohol and Drug Abuse Prevention and Treatment (ADAPT) Program: Time spent in the substance abuse clinic will be coded as BFFA. Time spent on substance abuse prevention will be coded as FAZS.
7. Drug Demand Reduction Program (DDRP): Personnel assigned to DDRP with not use MEPRS to account for their time.

8. Miscellaneous Activities: Miscellaneous activities will be coded as appropriate, including FEDA (administrative processing of medical evaluation boards, security clearances, court testimony, etc.), EBCL (OPR/EPR, Civilian Supervision), FALA (clinical and professional training), GBAA (military readiness training), GAAA (PDHRA non-clinical functions), EBCC (official committees or meetings, such as ECOMS and Prostaff), EBC* (squadron activities, such as squadron staff meetings and commander's calls), FCGA (military additional duties, such as honor guard) and GFAA (physical training). Other examples will be explained by the MTF MEPRS Monitor.

Table 1 provides a schematic overview of the general MEPRS coding guidelines for mental health personnel working in the Mental Health Clinic, ADAPT, FAP, DDRP, and BHOP.

Table 1.



MEPRS CODE DEFINITIONS

FAZY - **Preventive Mental Health Services:** Use this account to capture the cost and FTEs of briefings, workshops, and seminars provided and attended by groups or individuals for prevention education or raising awareness about mental health issues, meetings whose primary purpose is to promote the emotional health and welfare of the base community or population (e.g., CAIB and IDS), command consultation regarding specific programs, community issues, or population health, community crisis response (e.g., trauma stress response, hostage negotiation) and any other mental health promotion initiative (e.g., stress management, suicide prevention) conducted within the base community,

except substance abuse prevention. To be coded FAZY, these activities generally (but not always) must occur outside the mental health clinic.

FAZS – Substance Abuse Prevention: Use this account to capture the cost and FTEs of briefings, workshops, and seminars provided and attended by groups or individuals for prevention education or raising awareness about substance abuse. To be coded FAZS, these activities generally (but not always) must occur outside the substance abuse clinic. Clinical or administrative activities associated with the substance abuse clinic are coded under BFFA.

FAZF – Family Advocacy Program: Use this account to capture the cost and FTEs of operating, maintaining, administering, and supervising the installation Family Advocacy Program, to include Family Maltreatment Services, Family Advocacy Strength-based Services, the New Parent Support Program, and the Family Advocacy Outreach Program.

FAZN - Special Needs Identification and Assignment Coordination: Use this account to capture the cost of reviewing medical records, electronic encounter and treatment histories, interviewing family members, reviewing facility determination inquiries, and making recommendations for family member travel OCONUS and for special needs family member travel within CONUS. This account also includes time spent advising family members/unit representatives on procedures for the family member relocation clearance process, educating base personnel on SNIAC/EFMP requirements, data collection and reporting IAW DoD and AF requirements, and assignment coordination database/records maintenance. Wherever appropriate, code face-to-face time with customers in SNIAC as clinical encounters under BF**.

BW - Primary Behavioral Healthcare Consultation Service:** Behavioral Health Consultation Service (BHC Service) is a term used to describe any behavioral health service operating within a primary care clinic, using a consultative model of behavioral healthcare that is being delivered by a clinically trained Behavioral Health Consultant (BHC). In general, the goal of the BHC Service is to position the Behavioral Health Consultant on the healthcare team to augment and improve the delivery of overall healthcare, including behavioral healthcare. The BHC will not be used to provide comprehensive assessment or treatment of behavioral health conditions, as occurs in the specialty mental health clinic. The BHC may see the patient or perform limited interventions, but these activities are always designed to support the PCM's impact on the patients' health. On-going communication with the PCM regarding recommendations and the patient's status is key to the BHC's role. In contrast to specialty mental health settings, consultation by the BHC does not require a separate informed consent document since behavioral assessment and intervention are a part of the primary healthcare team's service. Moreover, documentation is recorded only in the medical record rather than in a separate mental health chart. The PCM remains in charge of the patient's care.